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INTRODUCTION — 1958 MEETING

By Amado Duiz Sanchez, M.D.

WALT WHITMAN of the long beard and the thoughts of childlike vociferousness, volcanic poet of America; friend of man and resurrected soul of a forgotten democracy; child of Manhattan, greatest of the north's sons, father of future generations and prophet of a new life; whose voice still rings across the Arizona desert, dashes against the Rocky Mountains, swims the turbulent waters of the Mississippi, to freeze into tangible sound in the waters of the Atlantic; Immortal Poet, Master of Men, I invoke thee and beg that some of the gossamer of thy spirit inspire me as I address these here present. Many of them have come from beyond our borders, from that country wherein you taught peace in labor and action in liberty. Thou, man made poetry and poetry made man, give me some of the wine of thy spirit with which to toast these men on friendship's road, so I may drink to that friendship that redeems passions and removes the frontiers of language, color and religion. Let thy spirit pervade this communion of men who are brothers in sentiment, which is our only weapon against the atomic auto-destruction of man.

In other places men are gambling with the destiny of the world; disputes rage and the dematerialization of matter is daily more imminent; men conceived in and nurtured on bitterness, apotheosize their hate. Yet here, where modern civilization has perhaps not reached its zenith, but love still survives; here where the sweet-scented *sempasuchitl* perfumes the forest and the Indian "reads with his sad eyes what the night stars write in passing"; here men of good faith congregate to make a covenant with the only goddess, Friendship, who can mold men into a brotherhood and they bring to her altar as their offering toward a fuller and more satisfactory life, their knowledge and experience in the struggle with the common foe — Death!

When science speaks, discord is silenced. When the tongue men speak is the language of love for those who suffer, of care and affection for those in need, when the word is a prayer to cure a moral wound or still a human pain, then and only then, without distinctions of color, creed or race, all men on earth profess the same ideal. When this happens, freedom is the fatherland. The nation is one, but freedom embraces all.

1958 — Third annual meeting Medical Society of the United States and Mexico, Guadalajara, Mexico.

Many Mexicans have sung to the Mexican nation. Giants of great stature and lineage have, like David of old, strummed on the heart-strings of this Indian Anahuac, given voice to that seed within our seed. Few have reached us with such gentleness and affection as the poet from Jerez, Lopez Velarde:

"Understand the ideal in art as harmony of future forms and within this the perfecting of humanity through beauty, none of our poets reach such noble tone color as Ramon Lopez Velarde." (R. Cuevas)

In a "necklace of superb hendecasyllables" Lopez Velarde lights "a lovely spiritual curve in the night of the nation." He sings to the "Gentle Nation" with tenderness and a child-like love; "his purified ego transcends egoism and becomes impersonal," speaking to the province in sweet arpeggios salted with the taste of tears; "As he accepted the divine bitterness of living in poetic continuity with the lovely objects that surround us," the demiurge understood the Mexican essence in all its details, and loved his country with a deep affection, as in this verse:

*"I will say with a muted epode
The Nation is sinless and diamantine"*

"Gentle nation: your carpet is the maise."

"Cuahutemoc:

*"Young Grandsire: here we praise thee only
hero grand as art."*

Let us loose the white doves of peace, liberty, and work, for this festival to brotherhood in the land of New Galicia. Let our hearts beat to the rhythm of pleasure and tenderness because today these men of two countries meet in common rejoicing. Let these errant gentlemen, hunters of death, take from their saddle-bags the pemmican of their experience and offer it to those who feel the need of correcting a misfortune, or quieting a pain, or shortening an anguish.

He gains more who gives than he who receives. The spirit of the doctor, of the investigator, of the teacher, the unitarian trilogy of this priest of the atomic age who dedicates himself to the search for a better way of being in human existence, is filled with joy at his abjuration. He renounces his own existence, con-

suming it in the practice of medicine, in investigation and in teaching. In this, spontaneous surrender of self is the sublime quintessence which lifts man toward the redemption of his own destiny, and by which he receives more, infinitely more, than the ill to whom he ministers in mitigation of an algia of his wounded body, or an anguish of his darkened mind.

William Osler, master of American medicine, patriarch of medicine made science through observation and study, work and investigation and refined to an art by the coparticipation of the spirit and imagination that welds beauty to health, once said:

"The desire for union, the eagerness for peace and the vehemence for concord firmly implanted in the human heart, have instigated the most powerful emotions of entire races and has been responsible for their noblest acts. One may say that this is only a sentiment, but is the world not directed by sentiments and passions? What, if not a profound sentiment, baptised this nation in blood? What, if also not a sentiment, is this deep love of our land so firmly implanted in the heart of all Americans that today has given to this nation, union, peace and concord? What happens to nations in general, happens to nations in particular. As happens to people, so to the individual. As in our profession, so to its members. This old and beautiful invocation to union, peace and concord, coming from our hearts and from our lips, can help us achieve our destinies."

I, too, with Osler, have faith that human nature, governed by those concerns dear to us, can rally to this trilogy of union, peace and concord, to achieve the spiritual tranquility of man and the well-being of this world, now being consumed in the altar fires of its disunity.

Let us begin with union, peace and harmony in the world of medicine. In the sphere of our professional activities, let us recognize our individual responsibility toward our brother doctors throughout the world and tighten those invisible bonds that spring from the mind and heart, to tie us all inexorably and forever to the sick.

Osler, master of automaticity and the perspicacious clinic, for whom medicine should be learned at the bed-side of the patient and not in the classroom, was also progenitor of the

idea that the most important element in the treatment of the disease was the treatment of the patient. He insisted upon cultivating the art of approaching the patient as a human problem to be solved through affection.

Today, even more than in the time of Osler of the golden heart, the paternal and kindly chat, the affable disposition, who effected more cures with a word of good advice than with a pound of medication, we should understand the indissoluble unity that exists between a diseased body and a sick mind. We should comprehend more clearly the anguish and somatic alterations of the man who has lost his natural harmonious function and thus become ill.

With Osler, I repeat, I would like to find in our profession a refuge for all men, the well and the ill. For they who are in search of psychic

or somatic assistance also serve to instruct and advance modern medical thought; and we, who in the application of our scientific art of healing learn the secrets of human nature when ill, daily become more capacitated to comfort a psyche weeping for its self-incomprehension, or a soma bleeding in pain. May all of us here find our refuge. May we fuse into one ideal, the noblest ideas of two nations, ours and those of the great American nation, and so form a splendid cultural synthesis for the care of the ill, irrespective of their social, racial or religious backgrounds, and for the advancement of medicine and scientific investigation. In unison let us fling forth the call of that colossus of Bonn, Beethoven, who sought to unite all of the unfortunate of humanity with the invisible cords of his sublime music:

MAN, HELP THYSELF!

BOOK REVIEWS

OFFICE GASTROENTEROLOGY

by Albert F. R. Andresen, M.D. 707 pages. Illustrated. (1958) Saunders. \$14.

A practical approach to the management of gastroenterological problems puts emphasis on histories and physical examinations. Chapters on the esophagus and rectum have been included and therapeutic diets are given special attention. Solid advice is based on personal experience in the care of patients.

Stacey's Medical Books, San Francisco, California.

PREVENTIVE MEDICINE FOR THE DOCTOR IN HIS COMMUNITY: An Epidemiologic Approach

by Hugh Rodman Leavell, M.D., and E. Gurney Clark, M.D. 2nd ed. 689 pages. Illustrated. (1958) McGraw-Hill. \$10.

Intended for those who are or will be in private practice. The subject is organized as: (1) basic principles, (2) applied principles; and (3) public health or preventive medicine as organized community action. New charts and diagrams, emphasizing basic principles, and a new chapter on the prevention of oral disease, stressing the importance of dentistry, have been added.

Stacey's Medical Books, San Francisco, California.

CLINICAL NEUROSURGERY, Vol. 4.

edited by Ira J. Jackson, M.D. 142 pages. Illustrated. (1958) Williams & Wilkins. \$7.

Its review of current thought about the management of pituitary and malignant breast lesions is especially valuable. Subtitles to this slim volume of the Proceedings of the Congress of Neurological Surgeons, 1956, would help: for example, (1) "Doctor Penfield on the Trail of Hippocrates and Temporal Lobe Function," and (2) "Aspects of Pituitary Adenomas and Hypophysectomy" would permit identification.

Stacey's Medical Books, San Francisco, California.

GENERAL DIAGNOSIS AND THERAPY OF SKIN DISEASES

by Hermann Werner Siemens, M.D. 324 pages. Illustrated. (1958) University of Chicago. \$10.

Here are basic dermatological principles illustrated with hundreds of close-up photographs. The chapters on therapy stress the importance of following proved rather than traditional methods. The result is a well organized resume of the field and a guide toward effective recognition and treatment of skin diseases. The translation is by Kurt Wiener, M.D.

Stacey's Medical Books, San Francisco, California.

ALOCUCION DEL DR. AMADO RUIZ SANCHEZ, EN LA SESION INAUGURAL

WALT WHITMAN, el poeta volcánico de América, el amigo de los hombres, el de la lengua barba y el de los pensamientos con clamor de niño el alma recurrente de una democracia olvidada, el mejor de entre los hijos del Norte, el hijo de Manhattan, padre de muchas generaciones por venir y cimiento de una vida, voz que clama en el desierto desierto de Arizona y se estrella en las Montañas Rocallosas, que se baña en las aguas turbulentas del Missisipi y se hiela en las costas del Pacífico; poeta inmortal, señor de todos los señores. . . Yo invoco a tu espíritu de hombre hecho de libertades y te pido un poco de tu inspiración para hablarle a los aquí presentes, venidos de allende la frontera, allá donde tú eres la paz del trabajo y la libertad hecha acción, y poderles decir que aquí en este Anahuac, también ha habido gigantes como tú, de tu raza y alcurnia, y quienes también nos han hablado al corazón de indio que llevamos y adoramos. Tú, señor de todos los señores . . . hombre hecho poesía . . . poesía hecha hombre . . . dame un poco de tu luz para brindar a estos hombres los caminos de la amistad . . . de la amistad que redime las pasiones y salva las fronteras del idioma, del color y de las creencias, convirtiéndose en comunión espiritual para todos los hombres hermanos de un mismo sentimiento . . . amistad que es la única arma que podemos oponer a la autodestrucción atómica del hombre, por el hombre mismo . . . y mientras en otras partes del mundo, donde se juega el destino de la tierra, las disputas crecen y los peligros de una desmaterialización de la materia son más inminentes cada día, endiosados los hombres en sí mismos y en odiar cada vez más a sus semejantes, aquí . . . donde la civilización es poca pero de amor es grande . . . aquí donde florece el sempoasuchitl como la flor silvestre de un aroma singular y aún el indio "lee con sus ojos tristes lo que enciben las estrellas de noche que pasan volando" . . . aquí, se congregan las gentes de buena voluntad, a rendir pleitesía a la única diosa que puede hermanar a los hermanos: la amistad, y a aportar su saber y experiencia en aras de hacer más llevadera y hermosa esta vida, luchando contra un enemigo

común la muerte.

* * *

Cuando la ciencia habla las discordias callan . . . cuando el lenguaje que los hombres hablan es el mismo, lenguaje de amor para los que sufren, de atención y cariño para los que lo han menester, cuando este lenguaje es oración que redime un sufrimiento moral o acción que suprime una dolencia humana, entonces, y nomás entonces, se hermanan todos los hombres de la tierra y sin distingos de color, de credo o de raza, profesan un mismo ideal . . . cuando esto sucede, !! *Patria es la libertad!!*, la patria es una la libertad lo es todo.

Al corazón de la patria mexicana le han hablado muchos mexicanos; pocos como el jerezano López Velarde han sabido acercársele con tanta suavidad y cariño.

"Entendiendo el ideal en el arte como la armonía de las formas futuras, y dentro de esto, el perfeccionamiento de la humanidad por la belleza, ninguno de nuestros poetas alcanza timbres tan nobles como Ramón López Velarde" (R. Cuevas).

En "un collar de endecasílabos supremos," López Velarde prende "en la noche de la patria una bella curva espiritual." . . . Canta a la "Suave Patria" con ternura y con amor de niño; "su yo depurado trasciende el egoísmo y se hace impersonal," hablando a la proviencina con arpegios dulces y sabor de llanto. . . . "Como aceptó la divina amargura de vivir en continuidad poética de los objetos prescotos que nos rodean," el demiurgo supo de la esencia mexicana en todos sus detalles y amó a su patria entrañablemente en este verso:

*"Diré con una épica sordina:
la patria es impecable y diamantina.*

* * *

Suave patria: tu superficie es el maíz.

* * *

*Cuauhtémoc:
Jóven abuelo: escúchame loarte,
único heroe a la altura del arte."*

* * *

Que se echen a volar las blancas palomas de la libertad, del trabajo y de la paz, que hoy hay fiesta de hermandad en esta tierra

neogalicia; que palpiten los corazones con goces de ternura, que hoy los hombres de dos países se reúnen con un mismo fin de alegría común: sacar de sus alforjas de caballeros andantes a caza de la muerte, legajos de su experiencia y brindarlos a todos los que han menester de un desmán que corregir, de un dolor que acallar o de una angustia que abreviar . . . con todo ello, goza más el que dá que quien recibe; el espíritu del médico, del investigador y del maestro, trilogía unitaria de este monje de la era atómica, que es el hombre que se encarga de buscar una mejor forma de ser a la existencia humana; su espíritu, decía, se llena de goce cuando se entrega de lleno, negando su propia existencia, a medida que se consume en el ejercicio de la medicina, la investigación y la enseñanza, y con esta entrega espontánea de sí mismo, quinta esencia sublime que lo eleva en la redención de su sutodestino, más goza él, infinitamente más, que el dolorido que la recibe y mitiga una algia de su cuerpo en llagas o una angustia de su mente obscurecida.

. . .

William Osler, el maestro de la medicina en América, el patriarca de la medicina hecha ciencia por la observación y el estudio, el trabajo y la investigación, y hecha arte por la participación de la imaginación y el espíritu, que plasman la belleza en la salud, decía una vez:

"El deseo de la unión, el anhelo por la paz y la vehemencia por la concordia, implantados profundamente en el corazón humano, han promovido las emociones más poderosas de las razas, y han sido los responsables de sus actos más nobles. No es más que un sentimiento, se podría decir: pero, No es dirigido el mundo por sentimientos y pasiones? Qué siní un sentimiento muy profundo bautizó con sangre a esta nación: y qué sinó también un sentimiento, ese cariño profundo por la tierra tan firmemente implantado en el corabón de todos los americanos, ha dado a este país de hoy unión, paz y concordia? Los que sucede a las naciones en general, sucede a una nación en particular; y así sucede con el pueblo como con el individuo; con nuestra profesión o con sus miembros; esta hermosa y vieja invocación por unión, paz y — concordia, desde nuestros corazones y desde nuestros labios, puede ayudarnos para lograr nuestros destinos."

Yo también, como Osler, tengo fé en que la naturaleza humana, gobernada por afectos que

le son tan caros, puede abanderarse de esta trilogía de unión, paz y concordia, para conquistar la tranquilidad espiritual de los hombres y traer un poco más de bienestar a este mundo que se consume en aras de us autodestrucción. !!Que haya unión, paz y concordia cuando menos en el mundo médico!!, que en el terreno de nuestra actuación profesional, cumplamos con nuestros compromisos vitales y estrechemos nuestros lazos de amistad, que son los mismos para todos los médicos del mundo, lazos que vienen del cerebro y van al corazón y que nos atarán, hasta siempre, con los hombres enfermos. . . .

Osler, el maestro por antonomasia, el clínico perspicaz, para quien la medicina debe aprenderse a la cabecera del enfermo y no en los salones de clases, y para quien, también, el tratamiento del enfermo es el elemento más importante en el tratamiento de la enfermedad, insistía en cultivar el arte de acercarse a los enfermos con cariño, como problemas humanos que hay que ayudar a resolver. Nosotros, hoy, más, aún que en los tiempos de Osler, el de corazón de oro, el de charla paternal y acogedora, el de carácter apacible, que más curaba con un buen consejo que con kilo de medicina, debemos comprender la unidad que hay, indisoluble, en el cuerpo enfermo y la mentalidad enferma, entendiendo mejor las angustias y las alteraciones somáticas, del hombre que ha perdido la armonía funcional de su naturaleza y se ha enfermado.

Como Osler, repito, quisiera que ésta fuera la casa de todos: enfermos y sanos; unos que en su basca de auxilio psíquico o somático, sirven de enseñanza y hacen avanzar con ello el pensamiento médico moderno; toros, que en su aplicación del arte científico de curar, aprenden los secretos de la naturaleza humana enferma y se capacitan cada día más, para confrontar una some que sangra dus dolencias . . . !!que ésta sea la casa de todos!! . . . que se hermanen en un solo ideal los nobles ideales de dos países, el nuestro y el la gran Unión Americana, en una bella síntesis cultural; por la atención de los enfermos (irreverentes de su condición social, raza o credo), por la enseñanza de la medicina, y por la investigación científica . . . y que al unísono, lancen el grito del coloso de Bon, de Beethoven, que quería unir a todos los hombres en desgracia, con las lazos invisibles de su música excelsia: *!!Hombre, ayúdate a tí mismo!!*

CONGENITAL ABNORMALITIES OF THE CORONARY ARTERIES

By Ian Stewart, M.D.

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CORONARY disease is of increasing importance to the health worker and the following notes may be of interest to those who have not encountered cases of congenital malformation. According to Smith (1950) descriptions have appeared in the literature since 1716 and the edition of Quains Anatomy of 1882, which devotes a good deal of attention to variations in the arterial tree, has this to say:

"The coronary arteries have been observed in a few instances to commence by a common trunk, from which they diverged and proceeded to their usual destination. The existence of three coronary arteries is not a very rare occurrence, the third being small and arising close by one of the others. Meckel in one instance, observed four, the supplementary vessels appearing like one of the branches of the coronary arteries springing directly from the aorta."

Three well defined conditions have been described and also a miscellaneous group of minor variations which are not only of little clinical significance, but are on the whole likely to escape notice at a routine post mortem. These will be discussed in turn.

1. The Single Coronary Artery:

Thomas and Loube (1947) found 22 cases in the literature and added nine unpublished cases, two of which they themselves saw. Of the 31, 17 were instances of the right vessel alone, 11 of the left vessel alone and in three its identity could not be established. They concluded that the defect was usually compatible with normal cardiac functions, but added an extra hazard in the presence of coronary artery disease because the available collateral anastomoses would need to be utilized early in life. One of their cases, a man of 22 years who died suddenly during exertion, and in whom the right vessel was absent, may have resulted from this.

In practically all the cases, the single vessel divides less than a centimeter from its origin. The missing vessel is usually represented by a small dimple or pouch. Smith (1950) recorded two more cases. One of these was a woman of 80 who died after an operation for malignant disease. There was a single left vessel and the right one was represented by a saccular dilatation. In his other case, a woman of 66 showed a single left vessel dividing 1 cm. from its origin. Smith states that, in 1950, 43 cases had been reported.

Alexander (1956) analyses the findings in 18,850 autopsies at the Los Angeles County Hospital between 1940 and 1949. Among the 54 abnormalities noted, most of them of very minor type, were four instances of absence of the right coronary, one of whom had lived to the ripe age of 82.

Campeau, Ruble and Cooksey (1957) saw a remarkable case of absence of the pulmonary valve in a man of 32 years in whom the left coronary vessel was absent and the right vessel divided immediately into three branches. There have therefore been at least 48 cases recorded. Alexander's survey suggests that the incidence of single coronary artery is about one in 5,000.

In the last five years, I have carried out about 900 autopsies in this district and met with the following two cases of single coronary artery.

Case 1.

An obese woman of 67 died suddenly at the tea table. As there had been no recent medical attendance, a coroner's enquiry followed. At the autopsy, the heart weighed 450 grams the increase being due solely to a deposit of epicardial fat. There was a single right coronary artery which divided immediately into right and left branches of normal caliber. The left

branch was almost fully blocked by a craggy mass 3 cm. from its origin and the obstruction had caused widespread fibrosis and thinning of the anterior wall of the left ventricle. The right branch had no constriction, but was fully blocked by adherent thrombus at 2 cm.

The bronchi were blocked by food and there were obvious signs of asphyxia, which was evidently a terminal accident.

Case 2.

A lean man of 65 years had suffered from precordial pain and dyspnea for some months. Screening of the chest showed no cardiac enlargement but an electrocardiogram "showed changes suggesting myocardial damage and right-sided preponderance." Because of his disabilities, he purchased a car to get to work. On the night of his death, he made a prolonged attempt to start it with the crank, failed, walked some distance uphill and fell dead at a bus stop.

At autopsy the heart was found to weigh 460 grams, the increase being due to hypertrophy of the posterior wall and septum of the left ventricle. Measurements taken at the middle of the ventricle were: Posterior wall: 2.5 cm.; septum: 2.0 cm.; anterior wall: 1.0 cm. The wall was muscular in all three sites except for a hair line of fibrosis under the endocardium of the anterior wall. It was thought that this part had been incapable of hypertrophy because of defective blood supply. There was a single large vessel arising from the normal site of origin of the right coronary artery. Its course was normal and it was moderately dilated. There was no obstruction. About 1 mm to the right of the ostium and also 1 mm. inside the ostium were two tiny vessels, each about 1 mm. in diameter, which wound to the right around the aorta and then followed the normal course of the left coronary artery. Before reaching the front of the heart, one of them divided into two branches. It was evident that the front wall of the ventricle had always had an inadequate supply and must have relied mainly on collateral branches from the right branch. The front wall of the ventricle had probably been abnormally thin throughout life.

The man served in the army throughout the first World War, played cricket and football in his youth, and carried out army physical training. He was fortunate not to meet the sudden end of the young man mentioned by Thomas

and Loube.

2. Origin of the Coronary Vessels from the Pulmonary Artery:

No instance has been encountered in the present series of autopsies. Swann and Werthammer (1955) saw three cases in a series of 623 autopsies in infants. One baby lived two days, one for three months and one for six months. They state that only 54 cases had been reported previously and believe the condition to be much more frequent than this figure would suggest. In two of their cases, the left vessel arose from the pulmonary artery and in the third, who only lived two days, both vessels arose from it. The size of the infant heart is such that unless one is aware of the condition, and looks closely for it, it will readily be missed.

Alexander's series of 18,950 autopsies only includes two of these cases, but he does not mention the proportion of infant death.

As the abnormal vessels deliver non-oxygenated blood to the myocardium, expectation of life is brief and the condition is one to be encountered in the still birth and in the young infant. This is not always the case as Jurishica (1957) records a case in a man of 18. He was rejected by the American navy because of a heart murmur, present during both systole and diastole in the pulmonary area. He had no symptoms and engaged actively in sport. An operation was carried out and a small patent ductus found and tied, abolishing a palpable thrill at the base of the heart. Six months later, as the persistence of the murmur had led to his rejection again by the navy, a second operation was carried out but death resulted from ballooning and rupture of the aorta. At autopsy the left coronary was found to arise from the pulmonary artery.

The defect results from an error in the development of the spiral septum of the truncus arteriosus, resulting in one or both ostia being in the pulmonary artery. Jurishica states that of 59 cases published, 48 died before one year and the rest survived into their teens or even into middle life.

Paul and Robbins (1955) suggested the instillation of talc into the pericardial sac to provoke vascularization. They report four operations. In three no anomalous vessel was found and the infants recovered. The fourth died and was found to suffer from endocardial fibroelas-

tosis.

3. *Coronary Vessel passing into Right Ventricle:* Davis et al. (1956) describe a unique case in a Negress aged 19. A continuous murmur in the pulmonary area led to thoracotomy. The left coronary artery was found, in its proximal half, to lie free. It then plunged into the muscle of the right ventricle. At this point a palpable thrill indicated free communication. Excision of part of the vessel abolished the thrill and when seen a year later, the woman was in excellent health.

4. *Minor variations in origin and distribution:*

Alexander gives a very detailed account of accessory branches, enlargement of the circumflex artery to take part of the right coronary supply, elevation of the ostia in the aorta and hypoplasia of the left ostium. These are in addition to those already quoted from his paper. Hypoplasia of the orifice of a vessel seems to be the most important clinically. The following case illustrates this:

Case 3.

A man of 45 years had been under observation for anginal pain for some weeks and died suddenly. At autopsy the heart weighed 310 grams, showed no valve lesion and no fibrosis of the myocardium. The left coronary artery was normally formed and healthy. The right coronary vessel had a pin point orifice leading into an artery of normal caliber. Close to the orifice was a tiny accessory vessel. No other organic change was found.

The hypoplasia may also occur in the stem of the vessel and the ostium be normally open. The following case, previously recorded (Stewart 1957) shows this.

Case 4.

A man of 42 years, who had made no complaint of illness and who had not been in medical care, was found dead in bed. At autopsy, the right coronary artery was found to be healthy. The left vessel was of normal caliber in its first 8 mm. and thereafter was only one third of the normal size. Seated on the entrance to the narrow portion was a small thrombus. As one would expect, this man had throughout his life studiously avoided even mild exertion.

Discussion:

It will be seen that there are a considerable number of types of malformation of the coronary vessels, ranging from those of no clinical significance to those incompatible with life. The minor variations, of no clinical import, are unlikely to be recorded accurately in the post mortem room and accessory vessels, for instance, are almost a commonplace.

So much is now being written, in both medical and the lay press, about coronary disorder and medical practitioners are so conscious of it that there now seems to be a "coronary neurosis" among practitioners over the age of 40. If this paper has no other purpose, it may remind such sufferers that it is a waste of time worrying. They may have had defective coronary arteries all their lives.

REFERENCES

1. Alexander, R. W. (1956) *Circulation* 14, 800.
2. Campeau, L. A., Ruble P. E. and Cooksey, W. B. (1957), *Circulation* 15, 397.
3. Davis, R. F., Dillon, R. F., Fell, E. H. and Gasul, B. M. (1956). *JAMA*, 160, 1047.
4. Jurishka, A. J. (1957) *Amer. Ht. J.* 54, 429.
5. Paul, R. N., Robbins, S. G. (1955) *Pediatrics* 16, 147.
6. Quains Anatomy (1882) 1,359. Longmans Green & Co., London.
7. Smith, J. C. (1950) *Circulation* 1,1168.
8. Stewart, I. (1957) *Med. Off.* 97, 191.
9. Swann, W. C., and Werthammer, S. (1955) *Ann. Int. Med.* 42, 873.
10. Thomas, J. D., and Loube, S. D. (1947) *Amer. Ht. J.* 34, 188.

BOOK REVIEWS

THE STUDENT LIFE: The Philosophy of Sir William Osler
edited by Richard E. Verney. 214 pages. (1958) Williams & Wilkins. \$4.

This is mainly an anthology from *Aequanimitas*, *An Alabama Student* and *Selected Writings*. The editor says that his book was compiled "... in the hope that an appetite will develop for all Osler's writings..." Some quotations have been slightly modified without covering footnotes. Biographical commentary is condensed, and Osler's name is omitted on the spine of the cover.

Stacey's Medical Books, San Francisco, California.

A TEXTBOOK OF CLINICAL NEUROLOGY

by Israel S. Wechsler. 8th ed. 782 pages. Illustrated. (1958) Saunders. \$11.

"A textbook..." casually flying the indefinite article, sails proudly into the fourth decade of its rejuvenations, reliably rewritten on a personal, honest basis of critical experience. To many it will be the short neurological text, and rightly so. Among its outstanding features is the historical chapter.

Stacey's Medical Books, San Francisco, California.

COMPLICATIONS OF BREAST SURGERY

By Robert S. Pollack, M.D.

San Francisco, Calif.

THE complications of breast surgery may be classified under latent and immediate groups. In the immediate group are obvious factors such as, hemorrhage, infection, anesthesia morbidity, motion of the arm, and wound healing. In the small, excisional biopsy procedures, complications are easy to control, but when we perform a radical mastectomy, these items are quite important.

To avoid hemorrhage requires meticulous hemostasis and cautious technique, in addition to a sound knowledge of anatomy. The same applies to the control of infection, a matter of surgical technique, training and attention to detail. The use of antibiotics, not as a routine measure, but when indicated is also necessary. Regarding anesthesia, one should be certain that the patient is not overloaded with depressants and anesthetic drugs. Adequate oxygenation is essential during any surgical procedure. It has been my experience that when anesthesia has been deep, and the blood of the patient dark, indicating poor oxygenation, there is an increased morbidity with accompanying nausea and vomiting. Keeping our anesthesia colleagues aware of the color of the blood during the operation will decrease post-operative discomfort.

Arm motion following radical mastectomy is begun the same day as the operation. The chest wall is bound with a heavy dressing, but the arm is kept free and motion started immediately. Certain exercises are used; finger creeping and crawling up the wall, raising the elbows to shoulder level, circular arm and shoulder swinging, and straight, upward elevation. Wound healing is enhanced by heavy bolster type dressings similar to the type one uses for skin grafting. I prefer this to placing suction catheters under the skin flaps.

The latent factors are more subtle and include lymphedema of the arm and lymphangiosarcoma, pregnancy, which can be considered a complication of cancer of the breast, the problem of the opposite breast, and the matter of

recurrences.

Let's talk briefly about swelling of the arm, or lymphedema. I think it is fair to say that every female patient who has had an adequate radical mastectomy will have some swelling of the arm. The fact that the amount of edema is unpredictable emphasizes an idiopathic factor regarding its etiology. One of the reasons for swelling of the arm is obesity. It occurs more frequently in patients who are just plain fat. Another reason is infection; also hemorrhage in an axilla which has not been properly drained causing increased fibrosis. In addition, improper and inadequate drainage of serum which normally collects in any large dead space enhances fibrosis and increases edema. An important factor in helping to prevent lymphedema is early arm motion.

Management of the Arm

Years ago, there was a tendency for surgeons to bind the arm in a position of rest following radical mastectomy. This is considered inadvisable. It may have been recommended because not enough skin remained to close the wound primarily, and therefore, the arm was pulled down in order to gain additional skin for closure. It also could have been due to a reluctance, in a certain number of mastectomies, to perform a skin graft. The matter of utilizing a skin graft has changed. Years ago, a skin graft was advocated for all radical mastectomies, during the last 10 years it has been performed very rarely. The reason for this is probably the selection of material. Today, cancers of the breast are seen in a much smaller and earlier stage and without much, if any, skin involvement.

In 1948, Stewart and Treves reported on six patients with lymphangiosarcoma developing in the lymphedematous arm. There have been other reports of this condition since then. It is a very aggressive, virulent, malignant lesion which develops long after the mastectomy (average 12 years). It starts in the chronically ob-

structed lymphatics and presents as a "purplish-red, subdermal, slightly raised, macular or poly-poid lesion on the skin of the arm near the anticubital fossa." It is solitary initially, but gets confluent with other areas. The lesions became nodular, may ulcerate, heal and break down again, and eventually cover the entire extremity with spread onto the adjacent chest wall. Radical amputation of the arm and shoulder girdle is the preferred method of therapy, if feasible. Metastases are pulmonary.

The exact etiology of this condition is unknown. When it was first noticed it was thought to be a Kaposi-like sarcoma, occurring on the upper extremities instead, as is more common in Kaposi's, on the lower. However, it is not a Kaposi's sarcoma, but is a definite entity itself, of serious nature. It has not been known to occur following a simple mastectomy or axillary dissection alone. Its cause must be related to the effect of a chronic block of the lymphatics in a heavily swollen, lymphedematous, upper extremity. In some cases reported there have been five-year survivals following amputation of the interscapulothoracic type. It is necessary to do this kind of amputation in order to circumvent the diseased extremity.

Role of the Opposite Breast

The opposite breast also may be considered a complicating factor following radical mastectomy for cancer. It is stated that between 4 to 12 per cent of patients with cancer in one breast will develop cancer in the opposite breast. A more accurate incidence is about four to five per cent. Treatment of the opposite breast by prophylactic simple mastectomy either at the time the radical mastectomy is performed, or at a selected time in the future is considered in some centers. Pack has advocated a simultaneous simple mastectomy of the opposite breast at the time the radical mastectomy is performed. Others advocate a simple mastectomy about two years following the radical mastectomy. They advise waiting in order to ascertain whether the patient's chances for cure are good enough to warrant a prophylactic procedure. The belief exists that if a patient is well for two years following a radical mastectomy, then it is justifiable to advocate a simple mastectomy on the opposite breast as a prophylactic gesture. It would seem, however, that if one is to do a prophylactic

amputation of the opposite breast, it should be done simultaneously with, or shortly after the radical resection because the benefit of doing the amputation can start only as soon as it is performed. By avoiding a two-year interval, there is that much less risk of getting cancer in the opposite breast.

As a practical matter, however, careful examination of each patient at regular intervals following a radical mastectomy is the commonly accepted procedure. A new lesion in the opposite breast can be detected at an early stage and proper therapy quickly performed. In fact, if we try to talk our patients into a prophylactic simple mastectomy of the remaining breast we have to do a very heavy job of salesmanship. Very few women will accept it. On the other hand, it is a logical consideration and should be discussed frankly with the patient.

Pregnancy can be a complicating factor following breast cancer. What to advise the woman who desires to have a family after a radical mastectomy has been performed is not simple. It has been found that patients who are pregnant at the time they have breast cancer do well if a radical mastectomy was done right away and the axillary nodes were negative. No interruption of the pregnancy is entertained. In patients who have breast cancer during pregnancy but at surgery have positive axillary node metastasis, the results are very poor, even if the radical mastectomy was performed promptly. Therefore, one may conclude regarding future pregnancies that when patients in the childbearing ages have cancer of the breast and a radical mastectomy has been performed, if the nodes were negative, childbearing may be undertaken with relative safety. When those patients with breast cancer had positive axillary node metastases at surgery, future pregnancy should be avoided, at least for a period of three to five years after the operation.

The final consideration in complications following breast cancer surgery is the treatment of metastasis. The best method for treating breast cancer metastasis is by irradiation. Other methods, in order of treatment, are ablation of ovarian function, either by surgery or by irradiation, the oral and parenteral use of hormones, and finally, if you have the energy, adrenalectomy and hypophysectomy.

GLAUCOMA SCREENING AT ARIZONA STATE FAIR

By Robert F. Lorenzen, M.D.*

Phoenix, Ariz.

THE importance of early detection in the management of chronic simple glaucoma has long been recognized. During recent years, mass screening techniques have been employed with increasing frequency as a means of diagnosing unsuspected cases, and of increasing the awareness of the general population and other physicians of the problem of *undiagnosed* glaucoma.

Members of the Phoenix Ophthalmological Society felt that the Arizona State Fair offered a unique opportunity for such a survey, with its public health booth, which for several years has screened large numbers of people with chest films, and various serologic tests.

Our survey was conducted under the joint sponsorship of the Arizona Medical Association, which generously financed the venture, and the Phoenix Ophthalmological Society. The Arizona State Department of Health was most co-operative in renting us space within their already limited area, providing assistants to record findings and aiding us in the tabulating of results, as well as carrying out follow-up investigations.

Our survey was unique in some ways. Most glaucoma surveys are done as a one "Glaucoma Day" operation, or over a period of months or years as part of routine examinations in certain specific segments of population, or in clinics. To my knowledge, this is only the second time that such a large scale survey of this type has been done covering a continuous period of several days. This is the first report of such a survey being carried out at a state fair. A county fair survey was carried out several months earlier in San Diego.(1)

The program lasted during nine days of the Arizona State Fair, November 1957, and was in operation from 10 a.m. until 6 p.m. with an

ophthalmologist examining patients during these hours each day.

Purpose:

The primary purpose of a survey such as this limited to tonometry (and ophthalmoscopy where increased tension was found), is to educate members of the general public, other physicians, and all others interested in health problems, with the importance of early detection of glaucoma and the methods of detection. The secondary purpose is to uncover unsuspected cases of glaucoma. The reason that the actual diagnosis of glaucoma is of secondary importance in such a survey is that unless a complete ophthalmologic examination is given to every person, it is not possible to rule out glaucoma in every case with a normal tension. Nor is it possible to make a positive diagnosis in every case with an elevation. Therefore, it is always important to emphasize to the subject that even though the tension may be normal at a given time, the problem of glaucoma is something for them to be aware of in the future, since some of the individuals tested and found normal in such a survey will eventually develop glaucoma. A false sense of security must not be imparted to those with normal tensions.

Method:

We conducted our testing in a section of the public health van at the fair. Each person tested filled out a card giving the usual pertinent data as well as any history of glaucoma. The test itself consisted of measurement of the intraocular tension by means of tonometry on each person 40 years of age, and older, who wished to have the examination performed. The test was done with the subject in a tilt back chair, after instillation of 0.5 per cent Tetracaine HCL (Pontocaine) for local anesthesia. Ophthalmoscopy was performed on persons with elevated tensions. A total of 14 ophthalmologists

*Members of the Phoenix Ophthalmological Society participating in the survey were: Drs. Aiello, Burgess, Carriker, Case, French, Lorenzen, Loveless, McFarland, Rhoades, Rice, Sage, Thoeny, Toland, Zinn.

donated 72 hours of time for these testings. In addition, we supplied each person who had the test performed with a copy of the booklet "Glaucoma," published by the National Society for the Prevention of Blindness, and discussed the disease while attempting to explain the purpose of the testing. A movie on glaucoma was also shown in an adjacent booth.

The only complications known to have arisen from the survey were three cases of corneal abrasion, one of which was under treatment for five days after.

Results:

During the nine days, a total of 1,220 persons 40 years of age or older were tested. A total of 21 of these were found to have an intraocular tension above that which we considered normal. All examiners followed the Schiotz scale of Sept. 20, 1954.(2)

Our follow-up covered a period of six months, and all of the persons with elevated tensions were contacted except one, who could not be located. Two persons advised the follow-up investigator that they simply had failed to go to an eye physician as advised, but that they did, indeed, plan to do so. One man stated that he wasn't the least bit interested in finding out the results of this test or any of the others, which incidentally revealed him to be a probable diabetic.

The 17 remaining persons with elevated tension all sought help, and seven were found not to have glaucoma. The remaining 10 are under treatment. These results are tabulated in the following table.

TABULATION OF SURVEY

	Totals	Per Cent
Number of people tested	1,220	100
Number with elevated tension (one or both eyes)	21	1.72
Of these with elevation		
Previous history glaucoma	0	0
Final diagnosis: Not Glaucoma	7	0.57
Final diagnosis: Undetermined	4	0.33
Final diagnosis: Glaucoma	10	0.82
(All under treatment)		

Our results reveal a somewhat lower incidence of glaucoma in a survey of this size than has been shown in several other reported surveys. (1,3,4,5). The significance of this lower incidence has not yet been determined.

Summary:

Glaucoma surveys are by no means the answer to the problem of glaucoma detection. However, such studies emphasize the importance and methods of glaucoma detection. This is a report on one such survey done at the 1957 Arizona State Fair under the joint sponsorship of the Arizona Medical Association and the Phoenix Ophthalmological Society, in which tonometry was performed on 1,220 persons 40 years of age or older. A six-month follow-up revealed that 17 of 21 sought help, and in 10 persons a definite diagnosis of glaucoma was made. These are under treatment.

550 West Thomas Road

BIBLIOGRAPHY

1. Power, John L.: San Diego Glaucoma Survey, *Am. J. Ophth.* 44: 696, 1957.
2. Editorial, New Calibration Scale for Schiotz, Gradle-Schiotz and McLean Tonometers, *Am. J. Ophth.* 39: 109, 1955.
3. Brav, S. S., and Kirber, H. P.: Mass Screening for Glaucoma, *JAMA* 147: 1127, 1951.
4. Vaughan, Daniel G., et al.: Glaucoma Survey of 1,000 Hospital Patients, *Tr. Pac. Coast Oto-Ophth. Soc.* 36: 99, 1955.
5. Horsley, M. E., Lewis, Philip, M., and Parker, Henry: Glaucoma Detection in an Outpatient Department, *JAMA* 166: 1265, 1958.

BOOK REVIEWS

EXTRACORPOREAL CIRCULATION
edited by J. Garrott Allen, M.D. 518 pages. Illustrated. (1958) Thomas. \$7.50.

The difficult problems in this field were discussed at a world-wide conference in Chicago, September 1957. With modern techniques and instrumentation, patients with reparable heart defects can continue to have increased benefits from operative interference.

Stacey's Medical Books, San Francisco, Calif.

OUTLINE OF ORTHOPAEDICS
by J. C. Adams, M.D. 2nd ed. 428 pages. Illustrated. (1958) Williams & Wilkins. \$8.

This excellent small book on basic orthopedics presents general surveys of methods of treatment and of orthopedic problems following which principal subject matter is given in regional order. Each condition in the different areas is briefly described.

Stacey's Medical Books, San Francisco, Calif.

Editorial Section

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The Editor sincerely solicits contributions of scientific articles for publication in ARIZONA MEDICINE. All such contributions are greatly appreciated. All will be given equal consideration.

Certain general rules must be followed, however, and the Editor therefore respectfully submits the following suggestions to authors and contributors:

1. Follow the general rules of good English, especially with regard to construction, diction, spelling, and punctuation.
2. Be guided by the general rules of medical writing as followed by the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.
3. Be brief, even while being thorough and complete. Avoid unnecessary words. Try to limit the article to 1500 words.
4. Read and re-read the manuscript several times to correct it, especially for spelling and punctuation.
5. Manuscripts should be typewritten, double spaced, and the original and a carbon copy submitted.
6. Articles for publication should have been read before a controversial body, e.g., a hospital staff meeting, or a county medical society meeting.
7. Exclusive Publication—Articles are accepted for publication on condition that they are contributed solely to this Journal. Ordinarily contributors will be notified within 60 days if a manuscript is accepted for publication. Every effort will be made to return unused manuscripts.
8. Illustrations—Ordinarily publication of 2 or 3 illustrations accompanying an article will be paid for by Arizona Medicine. Any number beyond this will have to be paid for by the author.
9. Reprints—Reprints must be paid for by the author at established standard rates.

The Editor is always ready, willing, and happy to help in any way possible.

(The Opinions expressed in original contributions do not necessarily express the opinion of the Editorial Board.)

WILL IT HAPPEN TO US?

Guest Editorial

CONGRESS convened in January, with a Democratic majority that was and is controlled to a large extent by the labor leaders who were instrumental in getting many of the members elected. High on the agenda of "must" legislation will be another onslaught against the private practice of medicine, probably by way of the Forand bill. We will again have to muster a united opposition to this alien philosophy. There is a chance that a coalition of conservative Republicans and Southern Democrats can defeat this attempt, and, further, that even if it were to pass congress, President Eisenhower might use his veto.

In any campaign, it is wise to consider all eventualities, and, if possible, develop plans for defense against them. Are we ready with a plan if the Forand bill becomes law? I have heard nothing to this effect emanating from the councils of the American Medical Association. Our representatives in organized medicine seem to be taking the attitude that it "can't happen here." It did happen in England and under very similar circumstances. The British doctors put up very little resistance, and they were divided and conquered with astonishing ease. Will the same thing happen here?

The only constructive ideas with which I am acquainted are those of the American Association of Physicians and Surgeons (AAPS). This national medical, conservative political group has advanced the theory of "non-participation." This phrase describes a plan of action to be taken by ethical physicians to protect their patients from the havoc of inferior medical care. Thus, they refuse to participate in schemes for distribution of medical care which are inimical to the best interests of their patients. But it also means that they will never withdraw their services from their rightful employers, their patients. The AAPS has spent thousands of dollars in determining that this principle is legal if invoked voluntarily to protect the welfare of the patient. This idea has worked in British Columbia, the Union of South Africa, and in Belgium. It could have worked in England if the doctors had been

better informed and organized.

This program in defense of the freedom of American medicine will require a unity and organization of our profession which we do not have at the present. We must bind ourselves together in a solid front so that when the time comes, we will not be divided and led by the "Judas goats" to the slaughter. In my opinion,

the best way this can be done is by a strong Arizona representation in the AAPS. This national organization is in the forefront of the opposition to all socialized trends in medicine and government, and, therefore, is ideal as a vehicle for our efforts to preserve the private practice of medicine. There is no time to lose.

SHAW McDANIEL, M. D.

OUR CLUE

THE ARIZONA election of November 1958 has been considered by some to be a paradox, as compared to the national trend. However, we must not assume that when the public is given a chance to truly express itself on clearly defined issues, that these expressions are false. The citizens of Arizona have proved that candidates for high office will be elected when they clearly, frankly and fearlessly present a truthful stand for the old-fashioned, conservative, constitutional form of government.

Party affiliations were thrown aside in the Arizona election as evidenced by the fact that these successful conservative candidates were by "name" representing a minority party.

We, in medicine, should profit by the approach of the Arizona candidates and be guided by the public's truly anti-socialistic vote. We must go to work and properly present the merits of free enterprise medicine, as contrasted to any form of governmental medicine. We will then surely be supported by public opinion. The expression of the Arizona citizenry is a challenge to us to formulate anti-socialistic programs and to guide them in fulfilling their desires to avoid socialized medicine.

As mentioned by Dr. Shaw McDaniel, we now have an organization, the AAPS, which, if properly supported and guided, will accomplish our mission.

L.B.S.

PHYSICIANS AS SLAVES

PERIODICALLY many physicians of national, and some of international reputations, get notices from hospitals on whose staffs they have been members for many years, notifying them that if they do not put their names on certain histories by a certain date their privilege of admitting patients to those hospitals will be withdrawn. These physicians are required to sign a statement on the front page of a history, long forgotten by them, to the effect that they have examined the entire history and found it to be correct. It is obviously impossible for those physicians to examine every word of these histories and correct the mistakes in the entries made by internes and nurses.

Why do the hospitals treat distinguished physicians of many years of practice in such a cavalier fashion? The answer is that they are compelled to do so by the Joint Commission on Accreditation of Hospitals. Of course the hospitals could, and, in my opinion, should, say to this commission, "Go to!" They are afraid to do it, though, because by doing so they would lose their accreditation and thus their ability

to get desirable internes.

Now let us consider who has set up these false and artificial standards. Are they distinguished practitioners of medicine, such as those who have been treated in the cavalier fashion recounted above? The answer is that some are and some definitely are not. A great many of the people who set these standards are hospital executives (some of them not even doctors), who have never been in private practice. There is evidence that the practitioners have been unduly influenced by the non-practitioners. Is private practice then to be controlled by a group of non-practitioners? It will be unless the entire body of practitioners get together and say to them, "Thou shalt not!" The hospitals have been put in the position of a starving man who becomes a thief in order to get food. They are doing things which are repugnant to the hospital staffs in order to meet certain requirements which will enable them to get internes.

The object of this Phillipic is not to say that we should not have standards for hospital accreditation. We should by all means have such

standards. The accreditation requirements have raised the standards of many of our hospitals in which the need was glaring. We should, of course, have standards of accreditation, but those standards should be fixed by the leading practitioners of our profession and not by leading "holiers than thou" who have never practiced medicine but who sit behind a desk and tell those of us who have been practicing all our lives how medicine should be practiced.

Practitioners know so well that the main consideration is the patient. They also know that a patient's best interests are served if a hospital has a good staff, if the records are properly kept, if the laboratory, X-ray, pharmacy, diet kitchen, etc., function properly. They also know that the best interests of the patient are not served if practitioners who are taking care of him are needlessly harassed by red tape.

Baltimore, long one of the world's great medical centers, has many fine hospitals. Some of the country's (and of the world's) leading doctors are on the staffs of many of these hospitals. Their valuable time is taken up by going to many useless staff meetings and committee meetings, which are held simply to meet the requirements of the accreditation commission. So much of their time is so taken up, that some of them no longer attend the city and state medical meetings which they formerly never missed.

What is to be done about it? Possibly the accreditation commission's rules are correct for a hospital in a small town in which there is only one hospital. But there should be some flexibility. Certainly the rules are not correct for a city like Baltimore, in which there are many hospitals and in which many physicians are on the staffs of a number of them. The garment should be cut to fit the cloth. Local conditions should be taken into consideration, and the rules should be modified on the advice of the local profession. This would be in the interest of both the profession and the hospitals, and, what is more important still, of the *patient*. It must be remembered that the patient is the center of the whole picture. Doctors, nurses, laboratory workers, pharmacists, technicians, orderlies, and the rest of the hired help, are only accessories after the fact.

Amos Koontz,
1014 St. Paul St.,
Baltimore, Md.

Reprinted by permission from Current Medical Digest, June '58.

FREEDOM OF CHOICE

"All our freedoms are a single bundle, all must be secured if any is to be preserved."—Dwight D. Eisenhower.

ONE OF the treasured traditions of America is the basic right of the individual to choose his own physician. This freedom of choice is as vital to medicine as freedom of the press is to newspapers. In both instances, it is the public that benefits.

Unfortunately, freedom of choice is being endangered in some areas of the U.S. by certain union and management health and welfare funds. Under these particular programs, the welfare fund controls—to a certain extent—the type of medical services rendered to union members and their dependents, who will render them, and the amount paid for those services. Not only is the individual denied the right to choose the doctor of his choice, he also is denied the right to change doctors when he feels he is not receiving satisfactory medical care.

The American Medical Association is deeply concerned about the future impact on the physician-patient relationship in plans in which the physician is not responsible directly to the patient.

The AMA consistently has supported voluntary mechanisms that respect the right of the patient to choose his own doctor.

But if this basic freedom is to be preserved, physicians must assume the responsibilities that go with it. They must give competent medical care. They must police their own ranks to eliminate professional incompetence and economic abuses.

If they shirk these responsibilities, they are likely to find themselves in the same position as thousands of patients — captives of the middle man.

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LETTERS TO THE EDITOR

Abbreviation Restricted

SEVERAL months ago, Mrs. Louise Alcott, R. N., executive secretary, Arizona State Nurses' Association, referred information and materials to this board concerning the "American Registry of Doctors' Nurses" which, apparently, is a private group or association which has been soliciting members in the State of Arizona. Also, we have received information from other state boards concerning the activities of this "association." Mrs. Alcott indicated memorandums concerning this matter were mailed to your association.

The Arizona State Board of Nurse Registration and Nursing Education is responsible for the administration of the law regulating the practice of nursing in the State of Arizona. In view of the activities of the "American Registry of Doctors' Nurses" and information which has been brought to our attention, indications are that individuals who become members of this association will feel they are entitled to practice in the State of Arizona as an "R.D.N." All of this information and material was referred to the attorney general of the State of Arizona for his opinion in relation to the members of this organization being employed, or offering to become employed, in the practice of nursing in this state.

The opinion of the attorney general specifies that "the use of the abbreviation 'R.D.N.' or 'R.P.N.' by any person other than a person who holds a license to practice as a registered nurse in this state is in violation of the Nursing Practice Act."

This board would appreciate if you would bring this information to the attention of the membership of your organization.

Mrs. Zona B. Brierley, R. N.,
Executive Secretary,
Arizona State Board of Nurse Registration
and Education

Women see physicians more often than men do, especially at the ages of 15 through 44. During childhood, however, boys receive more medical care than girls, reports Health Information Foundation.

The average person today sees his doctor about five times a year, Health Information Foundation reports. In the aggregate, Americans use between 800 and 850 million physician visits a year.

Pharmacists Aid AMEF

THE executive committee of the Arizona Pharmaceutical Association has endorsed a plan for pharmacists to donate to the American Medical Education Foundation. In the past many pharmacists have given Christmas gifts to physician friends to show their appreciation for past courtesies. For various reasons, these gifts have resulted in an economic waste of no benefit to the physician or the pharmacist.

Therefore the Arizona Pharmaceutical Association has advocated that its members donate to the AMEF instead of the Christmas gifts that they have given in past years. Of course this idea is just as voluntary as the giving or exchanging at Christmas, and it will take some time for many pharmacists to accept the idea. However the association feels that it is a very worthwhile plan and one that is in keeping with better professional relations.

We are pleased that the Arizona Medical Association and the American Medical Education Foundation will accept these donations in the spirit in which they are given.

Our president, Sam Reich, has written an editorial, and a past president, Richard J. Walsh, has written an article in the Arizona Pharmacist on this program. From time to time we will call this program to the attention of our members and we hope it will materially aid the AMEF.

We thank you for your co-operation for helping us to get this plan started.

Alfred J. Duncan,
Secretary,
Arizona Pharmaceutical Association

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EDITOR'S NOTES

SYMPOSIUM ON CANCER OF THE COLON
AND RECTUM (cont.)AMERICAN CANCER SOCIETY
OCTOBER 1958*X. Lymphatic Spread of Carcinoma of the
Colon and Rectum:*

Dr. Richard K. Gilchrist

The spread of cancer through the lymph system is by embolism. Cancer emboli are arrested in the regional lymph nodes where they either die, or grow. Further spread is by additional emboli. Cancer does not break through the capsule of the lymph node until there is extensive involvement and matting of these nodes. Of patients operated for cure, about two-thirds of those having cancer of the breast, bowel and stomach will have metastasis to lymph nodes at the time of surgery. Postmortem examination of patients dying in the hospital in the postoperative periods show that the surgeon often just misses removing all nodes containing metastatic cancer.

Under the stress of inflammation or endocrine alteration, cancer may flare up. That is, cancer that has been present but lying dormant may be activated by stress.

It is rare for high lying lymph nodes to be involved in cancer that arises at or below the peritoneal reflection; that is, rare for metastasis up to the root of the inferior mesenteric vessels.

The spread of cancer to the lymph nodes is predictable. Squamous-cell carcinoma of the lower rectum and anus will spread to the inguinal nodes. Cancer below the peritoneal reflection will spread lateralward and upward. Cancer of the colon above the peritoneal reflection spreads upward. Sigmoidal cancer rarely spreads above the level of the left colic vessels. The area of the splenic flexure, if this is involved with cancer, may have spread to the left gastroepiploic vessels and into the splenic area. Cancer of the traverse meso-colon may involve the greater curvature of the stomach.

Sixty-six per cent of the patients with cancer of the bowel have metastasis at the time they come to surgery and this is a spread by embolism. These metastatic cancer cells may then lie dormant for a prolonged period.

*XI. Management of Metastatic and Recurrent
Cancer of the Colon and Rectum*
Dr. Englebert Dunphy

Although cancer of the colon and rectum is among the more favorable forms of cancer for surgical extirpation, distant metastasis through vascular channels and late recurrences, locally or in areas of lymphatic spread are important causes of unsuccessful management. Occasionally such metastases are amenable to surgical excision or x-ray treatment.

If there is no evidence of metastasis at the time of surgery, and a satisfactory surgical procedure is performed one can anticipate a 75 per cent cure in these patients. However, in the absence of metastasis, the cure rate drops down to 15 to 30 per cent.

The biological status of the tumor is of greater importance than the employment of standard or super-radical operations. There are some tumors that are so unfavorable from the very onset that it matters little which surgical procedure is performed.

Venous extension occurs in 20 to 40 per cent of the cases. If it does occur, it is not necessarily hopeless. Frequently there is a long arrest of liver metastasis.

In the presence of liver metastasis, adequate surgery still should be performed upon the primary lesion. One should not leave any tumor that can be removed. Dr. Dunphy has never resected the liver for metastasis.

Peritoneal seeding: This is common in mucin producing tumors. It is a most unfavorable sign and if it is extensively present, it does contraindicate against even palliative surgery.

Local direct extension: In a late case, the presence of local direct extension may indicate a biologically favorable tumor and justifies the performance of a superradical operation, if there are no other metastasis.

Local seeding: This is all too common. There is a need for careful technique, a need for an "aspective cancer technique." This local seeding may account for histologically favorable lesions recurring.

Secondary or second primary tumors occur in 3 to 5 per cent of the patients. A second tumor is also amenable to resection just as well as the first one was.

Subtotal colectomy is indicated in the younger patient with numerous polyps.

In one patient, Dr. Dunphy removed the colon for multiple polyps but did not remove the distal

sigmoid; the polyps in this distal sigmoid are now disappearing after removal of the rest of the colon.

Indication to operate on recurrent lesions: 1. If the lesion is solitary. 2. If considerable time has passed before the recurrence or second lesion developed. 3. Location seems to be of little significance. 4. Operability must be weighed in the presence of multiple lesions.

For secondary resections, Dr. Dunphy has two patients living without recurrence for more than 15 years. Of 13 patients with recurrence who died, two died after five years, four after four years, three after three years and four in less than one year.

XII. Radiotherapy of Cancer of the Colon and Rectum:

Dr. Ulrich Hensehke

For curative treatment of cancer of the colon and rectum, radiation therapy should be used only when surgery is contra-indicated or refused. It is valuable, however, for palliation and as an adjunct to surgery. For palliation, radiation is helpful to most patients. External x-ray therapy is the treatment of choice for unresectable primary cancer and for metastasis in the abdomen, liver, lung, bones and brain. Interstitial radiation is preferred for perineal recurrences. Intracavity instillation of radio-active colloids is most effective for suppression of fluid formation. As an adjunct to surgery, radiation therapy is gaining importance. Pre-operative x-ray therapy is of definite value judging by experience of Memorial Hospital. Interstitial irradiation of unresectable and residual tumor during abdominal operation frequently results in good local tumor regression, symptomatic relief and occasionally long term survival. Intracavitary injection of radioactive colloids at the end of operations appears effective for treating scattered small tumor implants and destroying cancer cells spilled during operation.

At the Memorial Hospital in New York in the unresectable and recurrent cases, they gave these patients 1,000 to 2,000 r as a test dose to see if the tumor would respond. Some improvement was noted in three-fourths of the cases and these were given a full course of radiation therapy.

Radioactive colloidal gold or phosphorus has been found to be quite helpful in ascites in 30 to 65 per cent of cases. - Dr. Dunphy recom-

mends after closure of the peritoneal cavity injection of colloidal gold, p23 or yttrium 90.

Interstitial radiation is recommended for the non-resectable but localized lesions.

Radiation therapy is of very little value as a curative procedure, but it is some help in a palliative measure, and is of definite help as an adjunct to surgery. The author believes preoperative radiation treatment for rectal cancer is definitely helpful.

(Editor's Query: Will this run the course of pre-operative x-ray treatment for breast CA?)

XIII. An Assessment of the Spread of Carcinoma of the Colon and Rectum Into the Blood Stream, Body Cavity and Lymph Nodes - Dr. George E. Moore

A series of patients with surgically resectable adenocarcinoma of the colon and rectum were studied as to: 1. Blood vessel invasion. 2. Lymph node metastasis. 3. Isolation of tumor cells from the peripheral blood and blood specimens obtained from veins draining the primary tumor. 4. The presence of cancer cells in washings of the peritoneal cavity.

Blood vessel invasion was demonstrated histologically in approximately 73 per cent of the tumors. This was true in 63 per cent of the operable cases with invasion of the veins and in 90 per cent of the inoperable cases.

All specimens were cleared and two to 100 lymph nodes dissected out for histological study. At least one involved lymph node was found in 37 per cent of the cases. Peripheral blood samples were assayed for tumor cells before surgery. In 81 cases so studied malignant cells were found in only one case. However, at the time of surgery, tumor cells were found in the surgical blood specimens in 16 per cent of the resectable cases and in 37 per cent of the non-resectable cases. Blood samples were obtained from the inferior mesenteric vein both before and after manipulation of the tumor site.

When the abdomen was opened, the peritoneal surfaces were sprayed with saline and the fluid was screened for tumor cells. A similar specimen was obtained at the termination of the operative procedure. Tumor cells were obtained from the peritoneal washings in 35 per cent of both the resectable and non-resectable cases. The serosa does not have to be invaded to obtain these positive findings in the washings of pre- and postoperative specimens. Of these cells

that are obtainable, probably 90 to 95 per cent of them would be killed by the host.

XIV: Prophylactic Measures in the Treatment of Carcinoma of the Colon — Dr. Warren H. Cole

Three different groups, including their own, have emphasized the danger of implantation of cancer cells in the suture line following resection for carcinoma of the colon, and have noted a sharp reduction of this incidence by using precautionary measures such as irrigation, ligation of the lumen of the bowel, etc. In 1954, the authors reported finding cancer cells in the veins draining tumors of the colon and advised ligation of vascular trunks at the start of the operation in order to prevent dissemination of the cells.

Experimental and animal data in their laboratory indicates that operative trauma decreases the resistance of the host to cancer cells. If this reaction occurs in the human being, measures should be adopted to prevent or neutralize it.

We are still losing 40 to 50 per cent of these patients whom we should save.

Cancer has been noted to implant into ulcerated hemorrhoids or a hemorrhoidal incision. The same thing occurs at the anastomosis. In colon washings at the time of surgery, cancer cells were found in 43 of 45 cases. Dr. Cole believes that there is ulceration into the veins in 60 per cent of the cases, and certainly manipulation dislodges some cells. Consequently, he strongly encourages that the tumor be handled as little as possible. The bowel should be ligated above and below the tumor and the vascular trunk should be ligated at the start of the procedure.

In 65 per cent of 42 patients positive cells were found in the lumen between the ligatures. Within two hours they die outside of the ligatures.

In an effort to check as to the most effective drug now available to kill free cancer cells, he used normal saline solution, Terramycin, Clor-pactin and nitrogen mustard. The latter was the most successful.

Dr. Cole rarely found cancer cells in the peripheral blood and felt this was due to the effectiveness of the liver acting as a filter.

Nitrogen mustard is not used in patients over 70. When used, the total dose is 0.4 mg. per kg. of body weight. The maximum total dose is 30 mg. One-half the total dose is given at time of surgery, one-fourth total dose or a maximum of 7.5 mg. given intravenously into the portal vein and one-fourth of total dose the following day.

In the presence of breast cancer, he uses 15 mg. intravenously. These drugs are followed with white blood cell and platelet counts the first, fourth, seventh, and 14th postoperative days. Usually antibiotics have to be given because of the development of leukopenia. This check and anti-metabolite medication is repeated every four months for three times and then Dr. Cole uses TSPA every four months. The wbc count will drop in 25 per cent of the patients to 3,000. Wound infections have been minimal. Blood requirements have been greater in the patients receiving nitrogen mustard. These drugs work better in certain tumors than in others. There is certainly a need to assay the drugs against the tumor type and patient involved.

Operative stress and chemical stress decreased the resistance of the patient to cancer cells. This decrease in resistance is possibly up to 50 per cent.

Nitrogen mustard is now the best chemical available, but it is far from satisfactory and Dr. Cole recommends that its use still be limited to the research centers.

Forum consisting of Drs. Gilcrest, Dunphy, Hensehke, Moore and Cole

Preoperative irradiation for carcinoma of the rectum is carried out at Memorial only. None of the other participants used it.

They feel that three-fourths of the surgical cases are potential cures, in 5 to 10 per cent there is probably invasion of the bladder and prostate.

Dr. Dunphy believes that one whole segment of the large bowel may be particularly vulnerable to cancer, and possibly that a relatively wide segment should be removed for that reason.

They had not seen any metastasis from cancer of a polyp.

If the area of the inferior mesenteric artery is involved, there will be wide lateral metastasis and it is unlikely that a more extensive procedure here will greatly increase the cure rate.

Obstruction does affect the cure rate, probably cutting it down 50 per cent, for the obstruction has massaged the tumor and has probably spread cells. Of course, there must be a period of preoperative decompression, and probably a colostomy.

Cancer cells are being released all the time into the lumen of the bowel and possibly into the blood stream.

Gilcrest and Firor, in selective cases, removed the ovaries in conjunction with their resection of the large bowel for carcinoma.

Laterally involved nodes can rarely be resected, as far as Dr. Firor is concerned. These areas can be cleaned out if the hypogastric vessels are stripped clean, but the price is too great for the dividends to be obtained.

There seemed to be free cancer cells present in the abdominal cavity all the time. They grow best on a raw surface. Therefore, a number of these men did not recommend any of the super-radical pelvic procedures, for it merely gives these cancer cells a particularly good implanting surface.

These participants agreed that there is no satisfactory chemotherapeutic agent available at present. They did notice considerable nausea and vomiting on the use of nitrogen mustard, which they felt could be controlled with anti-emetics.

At Memorial Hospital, for their preoperative rectal irradiation, in the 10 days preceding surgery they administered 2,000 R, and sent the patient to surgery immediately following this.

Cancer cells will die in an infected field.

In perforating lesions of the colon with contamination, the peritonitis may have something to do with inhibiting the cells, particularly the cancer cells. Certainly frank peritonitis will kill cancer cells.

It was debated if the nitrogen mustard does not knock out the defense mechanism of the patient at times. They felt strongly that the clinician away from the research institution should await the development of newer compounds before chemotherapeutic measures are pursued.

They have used interstitial irradiation into hepatic metastasis in 15 cases.

Metastasis seem to go retrograde in the lymphatics only in the presence of an obstruction higher up.

The second look procedure was considered. Dr. Dunphy does not use it. He is waiting until results are obtainable. Dr. Cole would consider it particularly in the younger patient. Certainly they did agree that operation for recurrence is indicated. If Dr. Dunphy did a second look procedure, he would do it at approximately the two-year interval.

None of these surgeons had seen a patient with ulcerative colitis and a cancer of the colon who survived five years.

X-ray treatment in the preoperative period may greatly reduce the virulence of the cells. The irradiated cells may not have the possibility of transplanting at the time of spillage with surgery. Adjunctive radiation therapy certainly does modify the tumor cell, as has been proved in the presence of bone sarcoma.

BOOK REVIEWS

ELECTROCARDIOGRAPHIC ANALYSIS, Vol. 1: Biophysical Principles of Electrocardiography
by Robert H. Bayley, M.D. 237 pages. Illustrated. (1958) Hoeber. \$8.

The fundamentals of electrocardiography are clearly explained in this progressive, well-illustrated account. The fields of mathematics and electricity are utilized in the analyses. This volume is linked to *Clinical Applications of Electrocardiography* soon to be published. Serious students will welcome both of these exceptional treatises. The author is from the University of Oklahoma School of Medicine.

Stacey's Medical Books, San Francisco, Calif.

HANDBOOK OF TREATMENT OF ACUTE POISONING.
by E. H. Bensley, M.D. and G. E. Joron, M.D. 2nd ed. 212 pages. (1958) Williams & Wilkins. \$4.

Dealing only with acute poisoning, emphasis is on emergency measures. In handbook format, it is intended to aid physicians with limited experience in toxicology in the treatment of emergency cases. One section discusses basic principles and general plans and methods of treatment. A second section describes important types of acute poisoning and their treatments. The authors are from McGill.

Stacey's Medical Books, San Francisco, Calif.

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HARRY H. KUHLMAN, M.D.*1923 to 1958*

DR. KUHLMAN was born at Shattuck, Okla., on Jan. 29, 1923. His undergraduate work was done at Emmanuel College, Berren Springs, Mich.—B.A. degree, University of Southern California Medical School. Graduated June 1951. Interned a rotating internship at St. Joseph's Hospital in Phoenix until 1952.

He did a residency in obstetrics and gynecology in three parts at St. Joseph's Hospital, Phoenix, Ariz., Margaret Hague Maternity Hospital, Jersey City, and the Memorial Hospital at Kingston, N. C.

His education had been interrupted in 1945 and 46 when he served as an enlisted man in the U. S. Navy.

When his residency was finished, he served two years as a captain in the medical corps of the U. S. Air Force. When this was completed, he returned to Phoenix and was associated in the practice of obstetrics and gynecology with Dr. Raymond J. Jennett at 550 W. Thomas Road.

Dr. Kuhlman was eligible for the obstetrics and gynecology board; he was a member of the American College of Obstetrics and Gynecology, Maricopa County Medical Society, Arizona Medical Association, and the American Medical Association.

It has been written, "He will be remembered and missed by the residents, staffs, and by new physicians and those less proficient in obstetrics to whom he was adways very generous with his instructions and advice. He was especially active in the obstetrical department of St. Joseph's Hospital. He was uncompromising and accurate in the care of the sick, and his professional deportment was a standard by which other physicians may well be measured."

He is survived by his wife, Toni, and four children, Michele, 7; Mark, 6; Karla, 2; Joan, 1. He was preceded in death by his young son Mike, who died while Dr. Kuhlman was in the air force.

He died at his home on Nov. 9, 1958 of a heart attack.



Harry Kuhlman, M.D.

J. W. Kennedy, M. D.

Topics of Current Medical Interest

PHYSICIAN CO-OPERATION URGED

MEMBERS OF the Arizona Medical Association are urged to promptly turn in to the Industrial Commission of Arizona all current claims. Special attention is directed to the requirement and it is absolutely necessary that each procedure performed be properly "coded" in accordance with the Relative Value Fee Schedule in

effect since Aug. 1, 1958.

To make it possible for the industrial commission to submit to your fee and contractual medicine committee prior to fee schedule renegotiations proceedings to be held February next, certain necessary and requested cost estimates based on experience, it is absolutely essential that the membership involved extend full co-operation to this end.

THE ARIZONA MEDICAL ASSOCIATION, INC.

*House of Delegates — Annual Meeting
May 3, 1958*

ADJOURNED meeting of the house of delegates of The Arizona Medical Association, Inc., held in the Garden Room of the San Marcos Hotel, Chandler, Ariz., Saturday, May 3, 1958, convened at 8 a.m. Lindsay E. Beaton, M.D., speaker of the house, presiding.

Credentials:

The committee on credentials reported a quorum present and the assembly duly constituted.

Roll Call:

On roll call, 48 delegates (or alternates) and all members of council were present.

Minutes:

Minutes of the meeting of the house of delegates held May 1, 1958, were approved without reading.

Reference Committee On Resolutions:

Report of the reference committee on resolutions as amended was adopted with the following actions taken on motions regularly made and carried.

1. Revision of Articles of Incorporation and By-Laws

Whereas, the by-laws of The Arizona Medical Association, Inc., excepting for minor amendments duly adopted, have not been thoroughly reviewed since the date of association incorporation, June 19, 1950, and

Whereas, preliminary review of the existing articles of incorporation and by-laws of this association by its constitution and by-laws committee with advice of counsel indicates a definite need for revising both instruments at this time in order that each may be properly brought up to date and in conformity with one another, now therefore, be it

Resolved, that the house of delegates directs the constitution and by-laws committee through council to give immediate study to the problem and cause to be prepared with the aid of counsel, a recommended draft of revised articles of incorporation and by-laws for this association, and be it further

Resolved, that upon completion of such draft and circulation thereof among the members of the house of delegates of this association, a special meeting of the house be called for the purpose of considering and adopting an acceptable articles of incorporation and by-laws for the association.

It was regularly moved and carried that this resolution be adopted.

2. Budget Appropriations for the Fiscal Year 1958-59

The house of delegates of The Arizona Medical Association, Inc., adopted the budget of appropriations for the fiscal year 1958-59 as submitted.

This resolution was amended by the treasurer to include the dues for membership in the association being placed at \$70 per year, which includes \$10 per member designated for AMEF and that the sum of \$2,300 now in the checking account of the benevolent and loan fund be transferred to a savings account in that name.

It was regularly moved and carried that this resolution as amended be adopted.

3. Lead Poisoning, A Health Hazard to Children

Whereas, lead poisoning has been long considered a significant health hazard by the medical profession, and

Whereas, death has occurred in children from lead poisoning traced to repeated ingestion over relatively long periods of flakes of lead-containing paints from toys, nursery furniture and walls of dwellings, and

Whereas, an arbitrary limit of 1 per cent lead

in paint on these objects has been recommended by the American Standards Association and approved by the American Academy of Pediatrics as a maximum allowance for child safety and prevention of poisoning accidents from this source,

Therefore, be it resolved that action be taken by the Arizona Medical Association's committee on legislation toward providing a legal requirement of not more than 1 per cent lead content in paints marketed in Arizona on or for toys and nursery furniture or interiors of dwellings.

It was regularly moved and carried that this resolution be adopted.

4. Compulsory Assessment of Medical Staff by Hospitals

Whereas, physicians in recognition of their community responsibility are aware of and do participate actively in community projects, including various fund-raising campaigns; and

Whereas, such campaigns include a voluntary contribution to hospital building and maintenance fund drives; and

Whereas, a certain few hospitals are taking advantage of this voluntary participation through the promotion of schemes of compulsory donations which are ostensibly voluntary, but which amount to an assessment for application for or continuation of staff appointments, thus placing such appointment on a mercenary basis, rather than demonstrated ability and proved merit; and

Whereas, such a practice, if continued, could and would lead to a deterioration of medical service in the hospitals; and

Whereas, the American Medical Association, through its house of delegates, assembled in New York City, in regular session, June 1957, has adopted this same resolution condemning such compulsory assessment of staff members and/or applicants; therefore, be it

Resolved, that The Arizona Medical Association, Inc., through its house of delegates, assembled in regular session, May 1, 1958, at Chandler, Ariz., reaffirms this action of the American Medical Association, condemning the compulsory assessment of staff members and/or applicants by hospitals in fund-raising campaigns; and be it further

Resolved, that any physician approached in such manner report the fact to the secretary of his medical society; and be it further

Resolved, that copies of this resolution be sent

to the American Hospital Association, the Catholic Hospital Association, the Protestant Hospital Association, the Arizona Hospital Association, the American Medical Association, and to the secretaries of the county medical societies in Arizona.

It was regularly moved and carried that this resolution be adopted.

5. Arizona Central Cancer Registry

Whereas, The Arizona Medical Association, Inc., believing that it would be to the benefit of the physicians of this state, as well as to the public at large, to be able to evaluate more fully the effectiveness of cancer care, and

Whereas, it has been shown in many other states that a major contribution to various types of cancer study can be made by the establishment of a central cancer registry, which would provide much needed technical assistance to the various hospitals who may have now, or in the future, develop their own individual cancer registries, and

Whereas, a well functioning cancer registry program can serve as a tool through which the quality of cancer care in hospitals, or within a community, can be evaluated, and where deficiencies, if found, can be analyzed and steps taken for improvement, serving as a useful local point through which the effect of cancer control programs can be measured, and

Whereas, A central cancer registry would, furthermore, provide for valuable follow-up services almost impossible without such an agency, to do statistical analysis evaluation for all the hospitals participating in the registry program, and,

Whereas, A central cancer registry would receive abstracts of cancer cases from all participating hospitals and therefore the proper evaluation of the cancer problems in this state would be significantly expedited, and

Whereas, that a central cancer registry, when developed and established, would be most effective if it were a unit in the division of cancer control in the Arizona State Department of Public Health, and,

Whereas, with such a registry, The Arizona Medical Association, Inc., feels that the transmission of medical reports to a central cancer registry for statistical purposes can be done without violating the confidentiality of doctor-patient relationships, now therefore be it

Resolved, that The Arizona Medical Association, Inc., proposes and requests the state department of health to incorporate in its division of cancer control, an integral unit which will be known as a central cancer registry, either with or without enabling legislative enactment as deemed advisable, and be it further

Resolved, that the component medical societies encourage all its members, and the hospitals in this state to participate actively in furnishing follow-up information on cancer patients to the central control registry, and be it further

Resolved, That in the establishment of this central control registry, the sub-committee on cancer of the professional board of The Arizona Medical Association, Inc., be empowered to assist in helping to formulate policies concerning the operation, and the use of the data collected by the central cancer registry, and be it further

Resolved, that a copy of this resolution be sent to the Arizona Division, American Cancer Society; the Arizona Hospital Association; the American Medical Association; to Doctor C. G. Salisbury, commissioner of health, state department of public health; and to the secretaries of each component society of our association.

It was regularly moved and carried that this resolution as amended by the reference committee on resolutions be adopted.

6. A Medical School for Arizona

Whereas, At some time in the future the needs for formal medical education of qualified students in Arizona may not be met adequately as they are now by the Western Interstate Compact for Higher Education.

Whereas, any plans for meeting a future need for expansion of opportunities for such medical education should embrace the consideration of the establishment of a medical school in Arizona.

Whereas, the establishment and maintenance of a medical school is universally recognized as an extraordinarily expensive undertaking in the field of higher education, therefore,

Be it resolved, that The Arizona Medical Association, Inc., go on record as approving the establishment of a state supported medical school in Arizona at such time in the future as the unmet need for such a school is manifest and the State of Arizona is financially able to pay the costs of a school equipped and staffed for pre-clinical and clinical education on a nationally competitive level of excellence, and

Be it further resolved, that the council of The Arizona Medical Association, Inc., instruct the medical school investigating committee to continue its studies of the needs for medical education in Arizona and to co-operate fully with all interested individuals and state agencies who are now or in the future concerned with this problem.

It was regularly moved and carried that this substitute resolution of the reference committee on resolutions be adopted.

On motion regularly made and carried an "ad hoc" committee of the house was appointed to prepare a news release regarding the association's stand on a medical school for Arizona.

Election of Officers

The following officers were elected for a term of one year unless otherwise indicated:

President-elect, Dermont W. Melick, M.D., Vice President, Lindsay E. Beaton, M.D., Secretary, Leslie B. Smith, M.D., Treasurer, Clarence E. Yount, Jr., M.D., Speaker of the House, Paul B. Jarrett, M.D., Editor in Chief, Darwin W. Neubauer, M.D.

District Councilors: Central District (3 years), Donald A. Polson, M.D., Central District (3 years), E. Henry Running, M.D., Central District (2 years), Lorel A. Stapley, M.D., Northwestern District (3 years), Roy O. Young, M.D., Southern District (3 years), Walter T. Hileman, M.D.

1959 Annual Meeting

On motion regularly made and carried, it was determined that the incoming president-elect and the proper council committee determine the dates and location of the 1959 annual meeting.

Retiring Speaker's Comments

"I trust that you would allow me for a moment to abandon the anonymity of the chair and thank this house and preceding houses for the courtesies that have been afforded to me during my tenure as speaker. I have been your speaker for five years and there has been no part of my professional life which has been more pleasant and more rewarding to me. I should like everyone of you to know of my heartfelt gratitude for this privilege."

Meeting adjourned at 10:20 a.m., sine die.

Leslie B. Smith, M.D.,
Secretary

COUNCIL MEETING

MEETING of council of The Arizona Medical Association, Inc., held Sunday, Nov. 23, 1958.

*Membership Classification Changes**Cochise County Medical Society*

It was moved, seconded, and unanimously carried that Hugh M. Helm, M.D., be honored by elevation to 50 Year Club membership, as recommended by Cochise County Medical Society.

Maricopa County Medical Society

It was moved, seconded, and unanimously carried that Doctors Arthur C. Carlson, Otto E. Utzinger and Joseph Madison Greer be granted 70-year dues exemption, effective Jan. 1, 1959, as recommended by Maricopa County Medical Society.

It was moved, seconded, and unanimously carried that Doctor James L. Johnson be granted associate membership, dues exempt, account retirement, effective Jan. 1, 1959, as recommended by Maricopa County Medical Society.

Pima County Medical Society

It was moved, seconded, and unanimously carried that Doctors Selig A. Shevin and Margaret J. Cambier be granted associate membership, dues exempt, account illness, effective Jan. 1, 1959, as recommended by Pima County Medical Society.

It was moved, seconded, and unanimously carried that Samuel D. Townsend, M. D., be honored by elevation to 50 Year Club membership, as recommended by Pima County Medical Society.

It was moved, seconded, and unanimously carried that Doctor John E. Mulsow be granted 70-year dues exemption, effective Jan. 1, 1959, as recommended by Pima County Medical Society.

Pinal County Medical Society

It was moved, seconded, and unanimously carried that James M. Walsh, M. D., be honored by elevation to 50 Year Club membership, as recommended by Pinal County Medical Society.

CENTRAL OFFICE ADVISORY
COMMITTEE*Membership Addressograph Plates Use*

The chairman, by memorandum dated Oct. 17, 1958, stated:

"On Oct. 11, 1958, as chairman of council and vice president, I directed the secretary to authorize the mailing of material being sent out by the Citizens for Arizona State Medical School to

the physicians of the association. The secretary had called me for permission on this matter in the absence of the president. It was my understanding that a part of the mailing had already been made, using the addressograph plates of The Arizona Medical Association, Inc. The question asked of me was whether it was proper to complete the mailing.

My decision was made primarily on the basis that permission for the use of our addressograph plates had already been granted by the secretary, and that, whether or not that decision was advisable in the first place, The Arizona Medical Association should not go back on its pledged word, once given in good faith.

Since this courtesy has been given to a group known to favor the establishment of a medical school at Arizona State College, we must consider the question of furnishing our addressograph plates, on request, to organizations taking an opposite view of this particular controversy, in order to avoid the inference of partisanship on the part of the association.

It should be understood that these addressograph plates contain no material that makes the addresses printed from them identifiable as coming from The Arizona Medical Association, Inc. In other words, there is nothing on the printed address that could possibly imply any sponsorship by The Arizona Medical Association. It could, therefore, be argued that there would seem to be little objection in making our addressograph plates available as a favor to organizations that may wish to be sure of reaching every physician in the state, providing that there is no selection in granting the privilege, and providing that there is no danger of damage to the plates.

Since there has evidently been some friendly disagreement between various members of the society as to the appropriateness of releasing our addressograph plates to any outside organization, I am directing the executive secretary of the association to place this matter on the agenda of the council meeting of Nov. 23, 1958. Council can, at that time, establish a definitive policy for the future direction of the secretary and the executive secretary."

Discussion ensued regarding: (1) Whether or not these addressograph plates should be limited to central office use; (2) Whether or not these plates actually belong to the membership; (3) Whether or not restriction of use of the plates would be bad public relations; and (4) What

prior policy of use had been established, if any.

It was strongly recommended that the current policy of requiring submission of copy by prospective users, prior to authorization for use, be continued.

It was moved, seconded, and carried by a show of hands, 11 voting for and six voting against, that our addressograph plates be made available to medical, civic and educational organizations, as well as individual members of this association, but shall not be used for commercial or political purposes.

General Mailings from the Central Office

Question was raised regarding general mass mailings from the central office, and use of the official association letterhead for committee releases.

Discussion ensued regarding whether or not the secretary of the association should have the sole responsibility of approving such mailings.

It was moved, seconded, and unanimously carried that general communications be accepted by the secretary for distribution, if submitted, for example, by the chairman of any committee; if, however, he (the secretary) deems any to be questionable and should be rejected, a second rejection must be forthcoming from a second officer of the association, to be polled in the following order: (1) President; (2) Vice President; (3) President elect, before it is finally rejected.

Meeting Agendas — Advance Distribution

It was moved, seconded, and unanimously carried that chairmen of all committees (and boards) be requested to submit an agenda before a committee meeting call is issued by the central office.

Personnel Retirement Insurance Plan

Doctor Yount reported that the central office advisory committee feels that it should look further into the cost of providing insurance for "key personnel" of this association, and that it hopes to have a report for council at its next meeting.

Personnel — Fringe Benefits

Doctor Yount: As a fringe benefit for central office personnel, we (the central office advisory committee) recommend the association take up payments of the premiums on Blue Cross-Blue Shield benefits for all of our employes, the benefits of the policy to be determined by the amount of the salary which the association pays.

It was moved, seconded, and unanimously car-

ried that council adopt the recommendation of the central office advisory committee.

AMEF — ANNUAL ASSOCIATION CONTRIBUTION

Doctor Yount reported that he had prepared a voucher in the amount of \$8,657.50, representing the association's 1958 annual contribution to AMEF. This amount represents \$17.50 for collections last year, the balance of \$8,640 representing 1958 collections to date. Doctor Hamer, delegate to AMA, will present Arizona's contribution during the AMA house meeting in Minneapolis, Dec. 2 through 5, 1958.

FEE AND CONTRACTUAL MEDICINE COMMITTEE

VA Fee Schedule for Medical Services — Recommendation

The fee and contractual medicine committee, by letter dated Oct. 30, 1958, advised:

"Previously council referred to its fee and contractual medicine committee for consideration and recommendation, a VA schedule of fees applicable to participating fee basis physicians submitted by the veterans' administration for review and acceptance by this association applicable to the State of Arizona. A copy is enclosed with appendix attached.

The fee and contractual medicine committee met in meeting held Sept. 21, 1958, and due consideration was given the subject in hand.

It was concluded that the current Medicare schedule of fees should be submitted to the veterans' administration as an applicable fee schedule for the care of veteran patients, with the proviso that VA patients be screened by the VA and furnished with a certificate that they are to receive medical care indicated at the administration's expense through civilian physicians. The committee directed that a letter be forwarded to council conveying its thoughts in this regard, recommending such course for the further deliberation and action of council.

Under date of Oct. 14, 1958, M. J. Wollenman, M. D., Chief, Outpatient Service, VA Hospital, Phoenix, submitted a copy of partial fee schedule which has been mailed to all fee basis physicians in Arizona."

It was moved, seconded, and unanimously carried that we accept the recommendation of the fee and contractual medicine committee.

Panel Practice — Kentucky Legislation — Recommendation

The Mingo County Medical Society of West

Virginia submitted a copy of a proposed bill presented to the Kentucky state legislature, dealing with "panel practice," which failed of passage. This bill recites the following preamble:

An act relating to the practice of medicine.

Whereas it is the public policy of this state that, because of the close personal relationship between a patient and his or her physician, every person should be free from unreasonable restraints in the choice of his physician, and

Whereas it appears to the general assembly that when any person is a beneficiary of any medical service plan (whether financed entirely by said beneficiary, or partly by the beneficiary and partly by his employer, or entirely by his employer, or otherwise):

(a) He should not be required, as a condition to the receipt of medical benefits under said plan to waive his right to select his physician and to accept a physician selected by said plan or by any person other than himself, and

(2) Such a requirement or condition constitutes an unreasonable restraint upon such person's right to choose his personal physician,

Be It Enacted by the General Assembly of the

Commonwealth of Kentucky:

Section 1. As used in this act only, unless the context requires otherwise:

(1) "Medical service plan" means any plan or arrangement whereby one person provides or defrays any part of the cost of medical service to any other person.

(2) "Medical service" means any professional service in the field of medicine, osteopathy or dentistry which is performed by a licensed physician or dentist in this state.

(3) "Person" means any natural person or persons, or any partnership, association, corporation, co-operative, trust, or other legal entity, or any officer, agent, or instrumentality of any of the foregoing.

(4) "Beneficiary" means any person who in any manner receives or is entitled to receive medical service, or any part of the cost thereof, under any medical service plan in this state.

(5) "Physician," for the purposes of this act only, means any person licensed to practice medicine, osteopathy or dentistry in this state.

Section 2. No person operating a medical service plan in this state shall demand or require, as a condition precedent to the receipt of such medical service or any part of the cost thereof,

that any beneficiary waive or otherwise surrender his right to select the physician who shall perform a medical service for him or any member of his family. Every person operating a medical service plan in this state shall afford to every beneficiary thereof, the right to select the physician who shall perform such medical service.

Section 3. Every contract, agreement, or other arrangement the effect of which would deny any beneficiary under any medical service plan in this state his right to choose the physician who will perform a medical service for him or any members of his family, or impose as a condition to the receipt of said service or any part of the cost thereof that said beneficiary waive his said right, "is hereby declared to be contrary to public policy and wholly void."

Section 4. Nothing contained in this act shall prevent any person operating a medical service plan in this state from prescribing the fee which such plan will pay for a specific medical service. Provided, however, that no such person shall discriminate between qualified physicians, in payments made for like or substantially similar services.

Section 5. Nothing contained in this act shall prevent any employer from providing the services of a physician for employment and physical examination or first aid treatment at such employer's factory or other place of business, or require said employe to pay the value of the services of such physician to any employe who elects not to avail himself of such services.

Section 6. Every person found guilty of violating Section 2 of this act or of conspiring to do so, or of aiding or abetting another to do so, shall be fined not less than \$100 nor more than \$1,000, or confined in the county jail for not less than 30 days nor more than 180 days, or both.

Section 7. Any person operating a medical service plan in violation of this act and any person aiding or abetting any such person in the violation of this act may be enjoined from doing so by any court of competent jurisdiction in this state, upon the complaint of any beneficiary of such plan, or the commonwealth.

Section 8. If any person convicted of violation of this act is licensed to practice medicine, osteopathy or dentistry in this state, such conviction shall constitute sufficient grounds for the revocation of his license. If such convicted person is an officer or agent of a licensed hospital in this state, and the proof shows that such officer's or

agent's acts were committed with the knowledge and consent, express or implied, of such hospital's governing body, such conviction shall be sufficient grounds for the revocation of said hospital's license.

Section 9. Every beneficiary of a medical service plan in this state shall be entitled, upon demand, to receive the medical service or benefit provided by such plan, free of any unlawful restraint or limitation upon his right to select the physician who shall render such service. If any person operating or administering a medical service plan in this state shall, 15 days or more after proper demand has been made upon him, fail or refuse to provide such service or pay over such benefits to any beneficiary, except upon some condition declared unlawful by this act, such beneficiary shall have a cause of action against the plan and the person operating or administering the same for damages in a sum equal to twice the value of the service or benefit to which he was entitled.

Section 10. Every person operating a medical service plan in this state shall, on or before June 30 of each year, file with the secretary of state a designation of a process agent having an office in this state and upon whom service of process may be had by anyone having a claim against said plan. The secretary of state shall be entitled to a fee of \$3 for filing this designation. Failure to file said designation shall constitute a misdemeanor and shall be punishable by a fine of not less than \$10 or more than \$1,000 for each day the violation continues, at the discretion of the court.

Section 11. The provisions of this act shall have no effect on any medical service plan corporation organized under the provisions of KRS Chapter 273.

The fee and contractual medicine committee, following review, unanimously adopted a motion recommending to council that it consider the preparation and introduction of such legislation in Arizona.

Mr. Jacobson raised a question as to whether or not this bill would have been "constitutional" had it been passed.

It was moved, seconded, and unanimously carried that this matter be referred back to the fee and contractual medicine committee for their secondary referral to the legislation committee; and recently, that the article from the Minnesota

Law Review be distributed to members of council.

Third Party Contract — Hughes - Pima Society

The president requested discussion and advice from council regarding what consideration the fee and contractual medicine committee has given the problem. He continued by stating that: "the Hughes Company came to the Pima County Medical Society some time ago with a program wherein — don't misunderstand me, I'm not objecting to the amount of fees, I'm merely objecting to the philosophy, this plan is just like any of our other plans, whether it be Medicare, Blue Shield, or whatever it is — they want us to carry out treatment, surgical and I think some medical is considered, for set fees. At no time will that fee be beyond that which has been prescribed, regardless of the financial status of the individual. There has been a great deal of discussion. We tried in the board of directors meeting to consider some proposals, and I'm still not happy with the thought of the society as a whole, which I believe leans towards acceptance of this thing; and I merely wanted the board of directors to seek the advice of our fee and contractual medicine committee because once you establish such a precedent with this group in Tucson which is large, it involves some 18,000 employees and dependents, I think we should more or less agree, if we can, on a state level, whether we want to go along with this sort of thing, or is this contrary to our present day thinking."

Doctor Jarrett stated: "I think council should know this. By establishing a fee schedule which is based on this California Relative Value Schedule, so that we can affix a unit value and make this unit value vary, when the time comes, and it looks like it is inevitably coming that we are going to be forced to accept some type of fee schedule and enter into contractual arrangements with insurance companies or private industry, we could hook this facet to the cost of living, so that each year this matter could be renegotiated by contract, so that if the cost of living rose above, we'll say five points on the cost of living index that's published by the commerce department, then we would go up on our fees a corresponding amount; if it came down, we would likewise come down. Now, what we are concerned about mostly is the conventional arrangements with unions. They have always dearly loved this cost of living proposition and

geared their contracts to it, but there is no reason why they should object if we did the same thing. The important thing is initially to establish a good, fair, reasonable schedule for our purposes and I think maybe things will work out, but it is not going to be easy."

Doctor Beaton stated: "I think this is brought up mostly as a matter of information by Doctor Manning, and I want to assure you that the fee and contractual medicine committee's recommendations will be given great weight by the (Pima) County Medical Society. If all the societies can act together throughout the state in these matters, we are in a much better position than if one goes charging off in one direction and another in another."

No action taken.

MEDICARE PROGRAM

Council Meeting Oct. 5, 1958 —

Confirming Action

It was moved, seconded, and unanimously carried that we ratify the action of council in meeting held Oct. 5, 1958, accepting the Medicare committee recommendation to defer implementation of previous council action to allow sufficient time to evaluate the modified program prior to renegotiation of the Medicare contract on Feb. 28, 1959.

South Dakota State Medical Association — Resolution

For information of council, the South Dakota State Medical Association on Sept. 14, 1958, by resolution adopted, resolved: "That the South Dakota State Medical Association assert its opposition to the new Medicare program as being unwieldy, unsatisfactory, and far from the original intent of the program and that the following recommendations be considered:

- 1: Complete eradication of the Medicare program.

- 2: Creation of a group insurance program for military dependents allowing free choice of military or civilian facilities.

- 3: Return to the original program with adequate appropriations for its maintenance."

Received and filed.

PROFESSIONAL BOARD

Cancer Reporting as Communicable Disease — Legislation Recommendation

The following letter from the professional board of this association was read:

"The professional board, at a meeting held Sunday, Oct. 12, 1958, gave consideration to and

unanimously recommended that council give consideration to the introduction of legislation proposing an amendment to the statutes for and including the reporting of cancer, along with other communicable diseases, in the interest and protection of the doctor."

Doctor Hamer stated: "I think this action on the part of the professional board was unnecessary to begin with. This matter has already been taken care of by the house of delegates and they are a little bit late putting in a recommendation for something that has already been done, and that was the establishment of a cancer registry in the state department of health. It was confirmed by council and confirmed by resolution at our state meeting.

"If it is permissible, I would like to follow through and tell council what has been done so far in this matter. There has not been a meeting of the legislation committee and I didn't receive this early enough to send it out prior to this council meeting. Mr. Ozell Trask, an attorney, who has been very active in cancer activities and who was president of the state cancer society last year, kindly volunteered to prepare this legislation for us and, under date of Nov. 14, 1958, he submitted this proposed act, modifying the state health code to include the cancer registry, to Doctor Salsbury for his comments or suggestions; and since Doctor Salsbury is in the hospital, maybe he hasn't had a chance to see this.

However, the attorney general of this state did give the opinion that to form a cancer registry in the state department of health would require enabling legislation. On that basis, this bill which I will read, has been prepared by Mr. Trask in preliminary form:

AN ACT

"Relating to public health and safety; Providing for reporting contagious and neoplastic diseases to the state department of health, and amending Section 36-621 Arizona Revised Statutes.

Be it enacted by the legislature of the State of Arizona:

Section 1. Sec. 36-621, Arizona Revised Statutes, is amended to read:

Sec. 36-621. *Report of contagious diseases; neoplastic diseases*

A. A person who learns that a contagious, epidemic or infectious disease exists shall immediately make a written report of the par-

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ticulars to the appropriate board of health or health department. The report shall include names and residences of persons afflicted with the disease. If the person reporting is the attending physician, he shall report on the condition of the person afflicted and the status of the disease at least twice each week.

B. It shall be the duty of every physician and dentist to report or cause to be reported immediately to the state department of health the name, address, age and sex and race of every person who comes under his professional attention, and who, either by actual examination or by examination of specimens of tissue, is diagnosed or believed to have cancer, Hodgkin's disease, or leukemia or any other malignant neoplasm. He shall also report the primary site, grade and histological type of tumor, if known.

C. If a patient with cancer is not admitted to a hospital for treatment, the report shall be made by the physician or dentist to the state department of health on forms provided for this purpose. If a patient is admitted to a hospital for diagnosis and/or treatment, the report shall be made by the hospital to the state department of health on forms provided for this purpose.

D. The report of any case of cancer made pursuant to the provisions of this regulation shall be considered confidential and not open to public inspection."

It was proposed that we do not recommend the reporting of the patient's name and address; that these statistics be kept for statistical purposes alone, even though it will interfere with the follow-up; and that such information be passed along to Mr. Trask and the legislation committee. It was also recommended that all reports on cancer include a continuous pathological report number for identification.

It was moved, seconded, and unanimously carried that this council go on record as recommending to its legislation committee that any legislation drawn up on this subject state that names and addresses of patients will not be included; and recommended that some other means of statistical verification be provided.

Reporting of Suspected Active Tuberculosis — Membership Mailing

Doctor Smith raised question whether or not the association should stand the expense of mailing to each association member, for reporting purposes, a copy of committee resolutions,

adopted by council, or whether notice in *Arizona Medicine Journal* might not suffice for such distribution?

It was moved, seconded, and unanimously carried, that as a matter of policy, all such reportings be distributed through the medium of the *Arizona Medicine Journal*.

Sub-Committee on Aging — Permanent Status

The following letter, dated Nov. 17, 1958, addressed to council by the professional board, was read:

"Following the meeting called by the AMA council of aging held in Chicago, Sept. 13 and 14, 1958, attended by Doctor Lowell C. Wormley, representing the association through the professional board, the latter body, in meeting held Oct. 12, 1958, received the report of Doctor Wormley and after due deliberation, took the following action:

"That we (the professional board) recommend first of all that the Arizona Medical Association form a permanent committee on the problems of the aged or geriatrics; secondly, that we recommend and further urge that the president of the Arizona Medical Association impress on the governor, the necessity for gathering information that will reveal what facilities we have for the care of the problems of the aged in the State of Arizona at the present time, asking that the Arizona Medical Association have representation on any survey group that may be appointed; and thirdly, that once this information has been obtained, that the committee appointed by the Arizona Medical Association start functioning towards improving the deficiencies in the needed care, as brought out in this report for the aging in this state'."

Doctor John R. Schwartzmann, chairman of the professional board, commented:

"It may well be that this problem is so large that our general medicine subcommittee, out of which this board appointed or designated a subcommittee on geriatrics, cannot handle it along with its other assignments without additional help; or it may be council will wish to appoint an entirely separate committee to handle the problem, taking into account its magnitude'."

Discussion ensued.

Doctor Beaton stated that "a re-writing of the by-laws is going to provide, if approved, for the abolition of the definite specified subcommittee under the professional committee and

is going to allow the professional committee to appoint such sub-committees as it needs for the solution of problems at that time. So, under that re-writing of the by-laws, if the professional committee feels that it needs a gerontology committee, it will be allowed to appoint such a committee. I wonder, therefore, if the professional committee should not be instructed to await any implementation of this until the new committee set-up becomes effective under the new by-laws."

It was moved, seconded, and unanimously carried that the professional board be instructed to await implementation of the new setup under the re-writing of by-laws. At the time that such a sub-committee is appointed, that such sub-committee, through the professional committee, make a recommendation as to what kind of communication we should have with the state authorities for the establishment of a citizens' committee on problems of the aging.

PARKVIEW HOSPITAL, YUMA — ARBITRATION

"Nov. 8, 1958

Re: Parkview Hospital,
Yuma

Mr. John C. Smith Jr., President
Parkview Hospital
Yuma, Ariz.

Dr. Matthew L. Wong, President
Yuma County Medical Society,
Yuma, Ariz.

Gentlemen:

In the last few days, representatives of the Arizona Medical Association have conferred with representatives of both the Parkview Hospital board and representatives of the Yuma County Medical Society. The association is pleased to learn informally that all parties to the Parkview Hospital problem appear willing and anxious that the problem promptly be arbitrated.

More specifically, it would appear that the parties would be agreeable to accept as arbiters either Judge Henry C. Kelly and Supreme Court Justice-elect Charles C. Bernstein or a committee of six, composed of three doctors chosen by the council of the Arizona Medical Association and three members of the board of the Arizona Hospital Association. The former recommendation appears to have been one suggested by interested citizens from the Yuma area and we are informed that Judge Kelly and Judge Bernstein are agreeable to serving in this capacity.

Either method of arbitration, to us, seems excellent. However, as the interested citizens of Yuma have suggested the two judges, we are strongly inclined to recommend that route be adopted. Nor are we, as doctors, the least bit fearful that the fact that the problems involved may be medical in nature will in any wise prevent two non-medical men from arriving at a correct solution. These two distinguished jurists, by years of training and experience, have learned to discover and evaluate the necessary facts in a myriad of different professions, businesses and circumstances.

The state association, and myself as its president, want to express our hope that the parties will officially and promptly elect Judge Henry C. Kelly and Supreme Court Justice-elect Charles C. Bernstein as their arbiters; submit the entire problem to them and in an orderly fashion, and agree to abide by whatever decision and recommendations that are reached.

Finally, we want to congratulate all parties in their recognition of the necessity for a prompt and orderly settlement of the problem and are pleased the state medical association has been of some small help in this regard.

Very truly yours,

W. R. Manning, M.D.
President

Nov. 12, 1958

"W. R. Manning, M.D.

President, Arizona Medical Association, Inc.,
826 Security Building,
Phoenix, Ariz.

The governing board wishes it known that this recommendation is perfectly agreeable. The Parkview governing board hereby, officially and promptly, agrees to abide by your recommendation to lay the problem before Judge Henry C. Kelly and Supreme Court Justice-elect Charles C. Bernstein.

John C. Smith Jr., President,
Parkview Hospital, Yuma, Arizona."

Letter from the Yuma doctors who are members of the present existing staff of Parkview Hospital:

"Nov. 11, 1958

Wilkins R. Manning, M.D.
620 N. Country Club Road
Tucson, Arizona

Dear Dr. Manning:

In response to your recent letter to the Yuma

County Medical Society, the undersigned wish to inform you that we voted affirmatively for arbitration. However, we do not feel that many of the eight conditions proposed by the majority group were necessarily pertinent nor equitable.

Thank you for your interest.

Very sincerely, yours,

Wm. A. Phillips, M.D.
Joseph Waterman, M.D.
Charles B. Kaplan, M.D.
Martin Cohen, M.D.
Harold N. Gordon, M.D.
Marvin J. Wall, M.D.
John R. Arnold, M.D."

Following is a letter from Matthew C. Wong, M.D., president, Yuma County Medical Society:

"Nov. 11, 1958

Re: Parkview Hospital
Yuma

W. R. Manning, M.D., President
The Arizona Medical Association, Inc.
826 Security Building,
Phoenix, Ariz.

Dear Dr. Manning:

As we most earnestly desire this controversy to be solved, we will accept the council of The Arizona Medical Association, Inc., as an arbitration instrument on the present points of difference between the Parkview Hospital administration, and the majority of the Yuma County Medical Society.

We feel that you should take up all points of difference. Further we believe that the council and possibly its legal staff alone should be the mediating body.

We will be available anytime and place you desire to conduct this meeting. We are ready to supply any preliminary information you desire.

We feel the following should be included on the agenda:

(1) Full discussion of the by-laws as proposed by us on Sept. 30, 1958, with the view that they supplant the present by-laws of Parkview Hospital.

(2) Re-organization of the staff with all doctors of medicine of the community with immediate election and installation of officers.

(3) Only doctors of medicine on the medical staff.

(4) We reject the tenet that the administrator should sit in on medical staff committee

meetings, where matters of purely medical nature are discussed.

(5) We request a financial statement of Parkview Hospital.

(6) There should be a discussion of the radiologist and the administrator.

(7) Discussion of the possibility of an immediate public statement by the board of directors of Parkview Hospital that they have full confidence in the doctors of medicine who are now on the Parkview staff, and they should repudiate the inference that we are not really interested in good treatment of patients.

(8) Discussion of the medical staff having full executive power over its own function.

Respectfully submitted,

Matthew W. Wong, M.D.
President"

It was moved, seconded, and unanimously carried that the council go on record as approving the letter and actions of Doctor Manning set forth in the letter he wrote to Parkview Hospital and the Yuma County Medical Society, dated Nov. 8, 1958.

It was moved, seconded, and unanimously carried that a letter be written to the Yuma County Medical Society, with copies to the Yuma newspaper and Parkview Hospital, stating that council in meeting on Nov. 23, 1958, has given complete official ratification to the actions taken by its president (W. R. Manning, M.D.) in the dispute between members of the Yuma County Medical Society and Parkview Hospital, including his letter of Nov. 8, 1958; further, that the council reaffirms the willingness of The Arizona Medical Association, Inc., to assist in solving a situation that is obviously preventing the people of Yuma from getting hospital care that otherwise would be available to them; and further, it is council's hope that all parties involved will agree on some person or persons as arbiter, whether or not that involves this association, but that this association will remain ready to help whenever its good offices may again be requested, in good faith, by all parties to the dispute.

It was moved, seconded, and unanimously carried that the president and the vice president be empowered to act in the Yuma dispute on a day-to-day basis; and be further empowered that they are acting with the full consent of and in behalf of council.

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SEARLE

MEDICAL SCHOOL COMMITTEE

At the request of Doctor Running, the chairman read the Oct. 25, 1958, AMA report on medical education in collaboration with the Association of American Medical Colleges, for the information of council, favoring the establishment of two-year basic medical science programs wherever the environmental situation is favorable.

Opposition to Establishment of Medical School

Robert E. Hastings, M.D., alternate delegate, by letter dated Sept. 23, 1958, stated:

"Your letter relative to the special council meeting is at hand. I have already discussed the proceedings of council with Doctor Manning, our president, and I want to take this means of going on record about this whole situation.

I am unalterably opposed to the establishing of a medical school of any sort in Arizona, until such time as our population and financial ability as a state will allow us to establish a top flight, four year school. I feel that we are being stampeded into something that none of us, really, in his heart, wants. I agree that it is probably feasible to have a survey as suggested by the board of regents, and that if such a survey is going to be conducted, that it behooves the medical society to make a contribution toward that survey.

I do not feel that the fact that some money has been promised us by philanthropists in Scottsdale, should alter the picture in the least. If this man is generally interested in establishing a medical school in Arizona, the offer of a gift will stand until such time as the state needs, and can afford a top flight medical school. As you know, such things cost in the neighborhood of \$20 or \$30 million to establish, to say nothing of the exorbitant costs of maintaining such an institution. As it stands now, boys from Arizona who really wish a medical education, can get one under our interstate compact, with financial help from the State of Arizona that is far and away less expensive to the state, than would be the maintenance, let alone the establishment of an expensive medical school.

Once again, I wish to go firmly on record as being opposed to the establishment of a second-rate or two year medical school, either of which, I feel is not the answer to our problems, opinions of the council to the contrary notwithstanding."

Recommendation — Submission of Questions to the Board of Regents — Poll of Council Report

Doctor Melick: As far as these questions are concerned on a medical school, our committee got together and we agreed on the point that we should promulgate a number of questions which should be sent to the council for approval. There are approximately 100 questions that council was to review at this meeting. Our medical school committee has had only two actual basic premises in mind: (1) it's non-promotional, which I have reiterated time and again; and (2) that the Arizona Medical Association should not go on record or at least promote and get behind a medical school, at least until all the facts are in hand.

The president raised the question as to whether or not the Arizona Medical Association should do anything further in this regard at this time, in light of the situation whereby Russell Poor (Russell H. Poor, Ph.D., University of Florida) has been employed by the board of regents to determine what should be accomplished by a survey. Doctor Poor probably knows every question included in this list and certainly his recommendations to the board of regents will include answers to any questions that might be asked. After we have seen his report of what should be accomplished in a survey, then we can take a stand, or ask further questions.

It was moved, seconded, and unanimously carried that the medical school committee be directed to suspend any action with regard to formulating a questionnaire.

Doctor Melick requested direction of council as to what co-operation, if any, the medical school committee should give to Doctor Russell Poor in his preliminary survey for the board of regents.

It was moved, seconded, and unanimously carried that the committee give complete and entire co-operation to Doctor Poor in any way that he may request.

It was moved, seconded, and carried, Doctors Craig and Young dissenting, that

Whereas, there is almost daily stress placed on the Arizona Medical Association regarding the subject of a medical school in Arizona, and

Whereas, the council of the Arizona Medical Association passed a resolution on this subject to support the approach prepared by the board of regents (the regents have committed them-

selves to hire qualified experts to study the questions and supply the answers necessary to proceed), and

Whereas, the association emphasized that it will take no stand on the location of a school, now, therefore be it

Resolved, that the association or its committees do nothing further in this matter of location of a medical school beyond notifying the board of regents that the medical school committee will be available to aid in any way, if requested.

COMMUNICATIONS

Board of Medical Examiners — Governor's Appointments

Gov. Ernest W. McFarland announced he had re-appointed Zenas B. Noon, M.D., of Nogales for the term July 1, 1958 to July 1, 1961, and appointed Francis M. Findlay, M.D., of San Manuel for the term Sept. 18, 1958 to July 1, 1961. These appointments were in accordance with the recommendations of council.

AMA Acknowledgments — Arizona House of Delegates Resolutions

AMA acknowledged receipt of resolutions: No. 4 Compulsory Assessment of Medical Staff by Hospitals, and No. 5 Arizona Central Cancer Registry, as adopted by the Arizona House of Delegates, May 3, 1958. Received and filed.

Maryland Medical and Chirurgical Faculty — Veterans' Medical Care

The committee on veterans' medical care of the Maryland Medical and Chirurgical Faculty recommended:

"1. Limit federal medical care of all veterans to service-connected disabilities.

2. Have veterans with service-connected disabilities cared for by the armed forces hospitals or by local civil hospitals on a home-town care basis. U. S. Public Health hospitals might also be used to a limited extent.

3. If, and when, No. 1 and No. 2 are accomplished, a study should be made from the state level as to the disposition of the VA hospital facilities. Consideration should be given to turning them over to the states, possibly as hospitals for tuberculosis and neuropsychiatric patients.

4. That the Medical and Chirurgical Faculty of the State of Maryland appoint a properly financed committee to investigate the cost of patient care in VA hospitals in the State of Maryland, as compared with the cost of patient care in civil hospitals. There is reason to believe

that not only is the per diem cost higher (if all costs are included) but that the longer average stay of the patient in VA hospitals boosts the costs appreciably higher.

5. That the Medical and Chirurgical Faculty ascertain the number of additional hospital beds needed in Maryland if VA hospitals are disbanded, and that they encourage measures to provide such beds.

6. That the action of the faculty be communicated to the American Medical Association, and to all state medical societies.

7. That the faculty make an organized effort to get congressional action in order to consummate such of these aims as come within their province."

Maryland Medical and Chirurgical Faculty — Accreditation of Hospitals and Intern Resident Training Programs

The Maryland Medical and Chirurgical Faculty, at its meeting held Sept. 12, 1958, resolved:

"1. The Medical and Chirurgical Faculty of the State of Maryland based on its collective experience and study, hereby makes a finding of fact that the presently existing methods of approving and disapproving hospitals for accreditation adversely affect the potentialities and effectiveness of such institutions generally and the resident, intern and visiting physicians associated with such hospitals specifically;

2. The commission on accreditation of hospitals and the council on medical education and hospitals review and reconsider their objectives and their procedures and evaluation methods in achieving such objectives;

3. The opinions and findings of local medical societies be given more weight in appraising hospital facilities and services for accreditation."

AMEF — Arizona Action re Christmas Gifts by Pharmacists, Etc.

George F. Lull, M.D., president, AMEF, by letter dated Oct. 10, 1958, advised:

"On behalf of the board of directors of the American Medical Education Foundation as well as the medical schools who so surgently need our support, I am asking you to thank the council of the Arizona Medical Association for their recent action in support of the foundation.

I am sure that this is the genesis of a new source of income for the schools, and I am impressed with the imagination and foresight of your council's action."

Arizona Pharmaceutical Assn., Inc.

The Arizona Pharmaceutical Association, Inc., through its executive committee, endorsed a plan for pharmacists to donate to the American Medical Education Foundation.

Received and filed.

WMA Central Repository for Medical Credentials

Frank W. Barton, secretary, AMA Council on National Defense, announced that on July 1, 1958, the services of a central repository for medical credentials became available to doctors of the world.

PUBLIC RELATIONS BOARD**Arizona Press Club Awards**

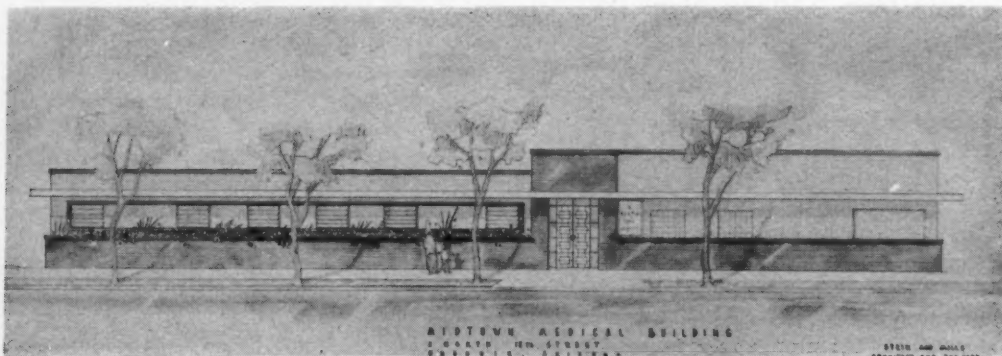
Doctor Polson referred to the newly proposed Arizona Press Club awards program and its request that our association continue participation, stating: "it was pointed out very forcibly that they expected us to do it but we didn't have to do it. I polled the public relations board and by a vote of eight for to three against, we decided to go along with it for value received in

press relations. It will cost instead of \$100, as we donated in prior years, \$300. If there is no objection, we will go ahead with it." Action ratified.

NATIONAL CASUALTY COMPANY — GROUP INSURANCE PROGRAM

The National Casualty Company of Detroit, underwriters of the association group accident and sickness insurance program, reported on its claims experience for the period July 15, 1956 to July 15, 1958, totalling \$68,764.35, reflecting an increase over the initial three year period (July 15, 1953 to July 15, 1956) which totalled \$80,332.67. Participation has dropped to 52 per cent. Council is requested to recommend a physician for each of the Tucson and Phoenix areas who will represent the insurance carrier on referrals for independent evaluation of cases. It was determined that the grievance committee would be available for such services.

Leslie B. Smith, M. D.,
Secretary

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PSYCHIATRY AND GENERAL MEDICINE

DANIEL Blain, M.D. will address the breakfast meeting at Camelback Hospital at 8 a.m., Tuesday, Jan. 27, 1959. His subject will be, "Psychiatry and General Medicine."

Dr. Blain was long-time medical director of the American Psychiatric Association. Toward the end of 1958, he accepted a position as director of the Mental Health Training and Research Project of the Western Interstate Commission on Higher Education on a half-time basis. He is also directing an APA sponsored "manpower project" concerned with the recruitment, distribution, and utilization of psychiatrists throughout the country. He accepted an appointment as professor of clinical psychiatry at the University of Pennsylvania and, in connection with the WICHE position, will work with departments of psychiatry at the Universities of Colorado and Utah.

The 1958 APA Biographical Directory credits him with over 45 publications. He has taught at Georgetown University since 1947, his last title there being that of Clinical Professor of Psychiatry. He is a member of AMA, ACP, APsAnA, A Psy-path A, ARNMD, A Soc S. His military record: Captain, USPHS 1942-1946.

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THE ARIZONA MEDICAL ASSOCIATION, INC. REPORT OF THE DELEGATE

Jesse D. Hamer, M.D., Delegate.

ACTIONS OF THE HOUSE OF DELEGATES,
AMERICAN MEDICAL ASSOCIATION,
12th CLINICAL SESSION
DEC. 2-5, 1958, MINNEAPOLIS, MINN.

YOUR delegate, as well as the executive secretary of the Arizona Medical Association, Mr. Robert Carpenter, attended all meetings of the house of delegates, as well as an all day session on Dec. 1, sponsored by the committee on federal medical services, of the council on medical service, dealing with various aspects of veterans medical care and the Medicare program.

This summary covers only a few of the many important subjects dealt with by the house of delegates, and is not intended as a detailed report on all actions taken.

Health care of the aged, the report of the AMA commission on medical care plans, osteopathy, expansion of medical education facilities, the association's administrative changes, the report of the committee to study AMA objectives and basic programs, and voluntary health organization fund raising were among the wide variety of issues considered by the house of delegates at the American Medical Association's 12th clinical meeting held Dec. 2-5 in Minneapolis.

Dr. Lonnie A. Coffin of Farmington, Iowa, was named the 1958 general practitioner of the year for his outstanding contributions to the health and civic affairs of his home community. Dr. Coffin, who is the first Iowan to receive the annual GP award, accepted his gold medal on behalf of "all the men who have dedicated their lives to the general practice of medicine."

Speaking at the Tuesday opening session of the house, Dr. Gunnar Gundersen of La Crosse, Wis., AMA president, called upon the medical profession to exert leadership and imagination in meeting the problems of these changing times. Urging practical actions to solve medico-economic challenges, Dr. Gundersen declared that "the time has passed for policies based on generalities, platitudes and flag-waving." He also suggested that the association offer support and co-operation to proposals for an International Medical Year.

Gov. Orville L. Freeman of Minnesota, who

also addressed the opening session, asked for "the help of the leaders of the medical profession in working out a program that will most adequately meet the needs of our older citizens for health care and services of the highest quality."

With half a day still to go, total registration Thursday evening had reached 4,880, including 2,870 physicians.

Health Care of the Aged

Responding to Dr. Gundersen's call for action and Governor Freeman's plea for help in meeting the health care needs of the aged, the house of delegates adopted the following proposal submitted by the council on medical service and endorsed by the board of trustees:

"For persons over 65 years of age with reduced incomes and very modest resources, it is necessary immediately to develop further the voluntary health insurance or prepayment plans in a way that would be acceptable both to the recipients and the medical profession. The medical profession must continue to assert its leadership and responsibility for assuring adequate medical care for this group of our citizens.

"Therefore, the council on medical service recommends to the house of delegates the adoption of the following proposal: That the American Medical Association, the constituent and component medical societies, as well as physicians everywhere, expedite the development of an effective voluntary health insurance or prepayment program for the group over 65 with modest resources or low family income; that physicians agree to accept a level of compensation for medical services rendered to this group which will permit the development of such insurance and prepayment plans at a reduced premium rate."

In order to effect the immediate implementation of such a program, the house directed that copies of the proposal be distributed to medical society approved plans, including Blue Shield and private insurance programs, requesting their co-operation.

Commission on Medical Care Plans

The long-awaited report of the commission on medical care plans, appointed at the 1954 clinical meeting in Miami, was discussed for two

hours at a reference committee hearing, but the house decided to defer action until the June 1959, meeting. In so doing, the delegates adopted this statement:

"We respectfully suggest to the constituent associations reviewing the report in the interim, that their attitude regarding the report will be clarified if they arrive at some decisions in regard to the following basic points:

"1. *Free Choice of Physician* — Acknowledging the importance of free choice of physician, is this concept to be considered a fundamental principle, incontrovertible, unalterable, and essential to good medical care without qualification?

"2. *Closed Panel Systems* — What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?

"These suggestions acknowledge that the policy of the American Medical Association to encourage and support the highest quality of medical care for all patients remains unchanged. They question, however, whether attitudes toward the free choice of physician and the closed panel system may be undergoing evolutionary change."

The house recommended that the board of trustees invite the constituent associations to forward their replies to these questions to the executive vice president 60 days in advance of the June 1959, meeting.

Osteopathy

Considerable discussion centered on a resolution which would have recognized that constituent medical associations have the right to establish the relationship of the medical profession to the osteopathic profession within their respective states. The house decided, however, that the resolution in question did not offer the appropriate solution to the osteopathic problem. Instead, the delegates requested the judicial council to review past pronouncements of the house on osteopathy and the status of the laws of the various states in this regard. The council was asked to present its report and recommendations at the June 1959, meeting. The house "noted with favor that the American Osteopathic Association has amended its objectives as stated in its constitution by deleting reference to the cultism of Andrew J. Still."

Medical Education

The house approved a statement by the council on medical education and hospitals supporting the development of additional facilities for basic medical education, and it urged the entire profession to give that policy strong support in order to correct misinterpretations of the association's viewpoint regarding the supply of physicians.

"American medicine," the statement points out, "fully recognizes the needs being brought about by the increasing population, social and economic trends, and the changing dimensions of medical knowledge and its application." Urging careful analysis of those needs, the statement says that existing medical schools should consider the possibility of increasing their enrollments and developing new facilities. It also declares that American medicine has the responsibility to encourage the creation of new four-year medical schools and two-year basic science programs by institutions of higher education which can provide the desirable setting.

AMA Administrative Structure

A board of trustees report on the administrative structure of the association was approved by the house, which termed the reorganization of the headquarters staff as a long and important step in the right direction. The report informed the house that the Chicago staff has been divided into the following seven divisions: business division, law division, communications division, field division, division of scientific publications, division of socio-economic activities, and division of scientific activities. The latter two are still in the process of development and are temporarily under the direction of the assistant executive vice president. The board also reported that the committee on legislation has been renamed the council on legislative activities, with the director of the law division as council secretary. This new council will undertake an enlarged, strengthened legislative program, closely co-ordinated with the activities of the new field staff and the Washington office. The latter also has been reorganized, with overall direction coming from Chicago.

AMA Objectives and Basic Programs

The house received and commended the report of the committee to study AMA objectives and basic programs, which it said may be a significant milepost in the association's history. In approving one of the committee's recommenda-

tions, the house referred to the council on constitution and by-laws the following amendment of Article II of the constitution:

"The objectives of the association are to promote the science and art of medicine and the betterment of public health and an understanding of the socio-economic conditions which will facilitate the attainment of these objectives."

The house also recommended that the board of trustees establish a mechanism which will assume the responsibility for promoting active liaison with each national medical society. "In the scientific fields," the house declared, "the role of the AMA should be primarily that of leadership, but every endeavor should be made to bring about co-ordination of the special fields of scientific interest of the other national medical organizations." The delegates also approved a recommendation that the board of trustees give serious consideration to opening the publications of the association to a free and open discussion of socio-economic problems applicable to medicine.

Fund Raising

Once again considering fund raising problems which have arisen since development of the concept of united community effort, the house passed a resolution which pointed out that the action taken last June in San Francisco has been interpreted by some as disapproving the inclusion of voluntary health agencies in United Fund drives. It then stated that "the American Medical Association neither approves nor disapproves of the inclusion of voluntary health agencies in United Fund drives." The resolution also requested the board of trustees to arrange a top-level conference with the voluntary health agencies, the United Funds and other parties interested in the raising of funds for health causes, with a view toward resolving misinterpretations and other difficulties in this area.

Miscellaneous Actions

In dealing with a wide variety of other subjects, the house also:

Took notice of the recent restrictive changes in the Medicare program; expressed regret at the substitution of federal facilities for private care in the areas mentioned, and urged the association to encourage the re-establishment of services under the free choice principle to accomplish the original intent of the act;

Recommended that the Social Security Act

be amended by congress to permit states to combine the present four public assistance medical programs into a single medical program, administered by a single agency and making available uniformity of services to all eligible public assistance recipients in the state;

Authorized the council on medical service to sponsor at the earliest practicable date a congress on prepaid health insurance;

Approved a plan to develop buyers' guides which will be sent to physicians to help their patients analyze the merits of available health insurance programs;

Approved a by-law amendment which will allow dues exemptions for interns and residents serving in training programs approved by the council on medical education and hospitals;

Called to the attention of all individuals or institutions responsible for intern and resident training that medical services provided to patients in hospitals are the responsibility of duly licensed physicians;

Encouraged the voluntary registration of the paramedical personnel who assist physicians, but opposed the extension of governmental licensure and governmental registration at this time;

Heartily approved and lauded the purpose, content and format of the *AMA News* and recommended continuance of the publication under its present and established policies;

Agreed with the committee on medical practices that relative values studies should be conducted by each constituent medical association but not on a national or regional basis by the AMA;

Urged each constituent society to establish a committee on rehabilitation to carry out activities recommended by the board of trustees;

Called for continued activity at all levels to stimulate the development of effective poliomyelitis inoculation programs;

Suggested that the association take immediate steps toward developing a plan whereby reserve medical units and individuals not immediately involved in military operations could be used to supplement civil defense operations, and

Expressed gratitude and appreciation for the long years of devoted service by Dr. Austin Smith, who has resigned as editor of *The Journal of the American Medical Association*.

At the opening session, six state medical so-

cieties contributed a total of almost \$250,000 to the American Medical Education Foundation. The gifts were: California, \$150,305.75; Indiana, \$35,110; New Jersey, \$25,000; New York, \$19,608; Utah, \$9,977.50 and Arizona, \$8,657.50. In addition, the American Medical Association announced a contribution of \$100,000 to the foundation.

It also was announced on the opening day of the meeting that Dr. W. Linwood Ball of Richmond, Va., AMA vice president, had been appointed to the board of trustees to fill the vacancy caused by the recent death of Dr. Warren Furey of Chicago. Dr. Ball, who will serve on the board until next June, said he will not be a candidate to succeed himself.

THE PHYSICIAN'S ROLE IN THE SOCIAL SECURITY DISABILITY PROGRAM

By Palmer Dysart, M.D.

Medical Consultant,
Disability Determination Section
Division of Vocational Rehabilitation

WHAT is wanted when a doctor receives a medical report form from Social Security? Let me explain —

Doctors, hospitals, institutions, and agencies who have contact with disabled people are frequently asked these days to fill out medical reports in connection with claims under the disability provisions of the social security law. These provisions protect severely disabled people in three ways:

1. Benefits are provided for insured workers age 50-65 who are no longer able to work because of an extended total disability. Beginning September 1958, benefits may also be paid to certain of the disabled workers' dependents — namely, wives and dependent husbands who have reached retirement age, unmarried dependent children (including sons or daughters disabled in childhood), and wives, regardless of age, who have in their care children entitled to benefits.

2. Benefits can be paid to adult disabled sons and daughters of retired workers and of workers who have died. To be eligible for these benefits, the disabled son or daughter must have a disability which began before age 18 and has continued uninterruptedly.

3. Disabled workers, regardless of age, can "freeze" their social security records to protect their own and their families' future benefit rights.

To qualify under these disability provisions, a person must be unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or to

be of long-continued and indefinite duration. A disabled worker must, in addition, have social security credits for work in at least five out of the 10 years before he became disabled and must be fully insured. The social security credits needed for a fully insured status vary from person to person depending on age. Five years of work under social security will be enough to meet the "fully insured" requirement through 1960. Anyone with 10 years of social security credits is fully insured for life.

Benefits are not payable for the first six months that a person is disabled. However, as in the case of the old-age insurance benefits, the law protects a person who delays filing his application for some time after he meets the requirements for payment (including the six-month waiting period), in that it permits back payments for as much as 12 months.

Workers with long-standing disabilities have until June 30, 1961, to apply to have their social security records frozen as of the time they actually become disabled. In some cases this may be as far back as October 1941, the first date when the work requirements could have been met.

Under the social security law, the benefits payable to a child ordinarily stop at age 18. Where a disabled child was entitled to benefits before age 18, his benefits will be continued so long as he is disabled. Otherwise, his benefits begin when the parent on whom he is dependent becomes entitled to disability benefits (age 50-65) or to old-age insurance benefits, or dies, regardless of the child's age at that time. In contrast to the applicant for disability insurance

benefits or for a "freeze," the disabled child does not need a record of work under social security. The disabled child must, however, meet the same definition of disability as disabled workers. The mother of the person receiving this type of benefit may qualify for mother's benefits if she has the disabled son or daughter in her care.

Role of State Office

All applicants, whether for benefits or for the freeze, are referred to their state vocational rehabilitation services. Payments to the disabled worker and his eligible dependents are suspended, if the disabled worker refuses, without good cause, to accept available rehabilitation services. However, all referrals to vocational rehabilitation services may not be accepted for such services because of factors involving feasibility such as advanced age, marked severity of impairments, attitude, etc., which might adversely affect efforts to return the individual to employment. On the other hand, if the disabled worker accepts the rehabilitation services and performs work pursuant to an approved state vocational rehabilitation program, benefits may continue for as much as 12 months after he starts that work.

Applications under the social security disability provisions are taken by the 584 social security district offices, located in communities all over the nation. The social security district office gives the disabled applicant information about his rights, helps him to fill out his application, and advises as to the proofs and documents he may need to support that application. Under the law, the disabled person is responsible for furnishing, at his own expense, the evidence to show that he is "disabled" within the meaning of the social security law.

His social security district office gives him one or more copies of a medical report form on which this evidence can be supplied. He is asked to take or mail this form to his attending physician or to a hospital, institution, public or private agency where he has been treated for his disabling condition. This report form, designed as a guide for the reporting physician lists the kind of medical facts essential for the determination of "disability." However, the reporting doctor is not required to use it; if he prefers, he may make his report in the form of a narrative summary or he may submit photocopies of the pertinent medical records. The completed reports are to be returned by mail

to the social security district office (or to a state agency, if indicated).

By providing a full and objective clinical picture of his patient, the reporting doctor fulfills his responsibility to his patient, and incidentally, expedites the decision. To be of maximum use for the evaluation of a patient's capacity for work, the report should include a history of the impairment, the symptomatology, clinical findings, diagnosis, and course of the disease with objective findings during acute phase and after maximum improvement has occurred. It should be noted that the attending physician is asked only to provide this type of objective medical data. He is not put in the position of having to decide the issue of "disability." The determination as to whether a patient is "disabled" must be made within the scope of the social security law; often it is based on evidence from more than one medical source. Also the determination must take into account factors which are not purely medical — factors such as education, training, and work experience.

After the applicant has filed his claim under the disability provisions, and furnished the supporting evidence, his case is forwarded by his social security office to an agency of his state — usually the state vocational rehabilitation agency. Under agreements between the individual states and the federal government, these state agencies make the disability determinations for their own residents.

In the State of Arizona, the agreement with the federal government provides for the division of vocational rehabilitation to make these disability determinations, and for this purpose a disability determination section was set up.

Evaluation Requirements

The evaluation of disability is made by a "review team" in the state agency. There are at least two professional people on each team. One of the two is a doctor of medicine (often a practicing physician who serves with the state agency on a part-time basis); the other is trained in evaluating the personal and vocational aspects of disability. The team must decide whether the applicant is sufficiently disabled to prevent him from engaging in any substantial gainful activity within the foreseeable future. Such activity is not limited to former types of employment.

In many cases it is necessary to write back

to the reporting physician because the medical report does not contain enough clinical facts. As a rule, the kinds of medical facts that the attending physician needs in making his diagnosis and in treating his patient are the same as those required to evaluate the severity of impairments in disability programs. However, certain medical facts are more highly significant in disability evaluation than to medical management of the case. To evaluate the effect of the impairment on the individual's ability to work requires the kind of medical evidence that confirms the diagnosis and measures remaining functional capacities of mind and body. By furnishing complete and objective evidence, the reporting physician makes it unnecessary for the reviewing physician to request additional clinical or laboratory data.

Where the medical evidence initially submitted indicates a reasonable likelihood that the applicant is disabled, but more precise clinical or laboratory findings are needed to arrive at a sound decision, or to resolve conflicts in the evidence, a consultative examination (usually at the specialist level) may be requested to obtain additional information. Selection of consulting physicians and payment of fees are governed by state practices.

Some doctors feel that they should be reimbursed by the government for the cost of preparing the initial medical reports on their patients, and it is of course, quite within their prerogative to charge the patient a fee for that service. However, under the law, the social security administration cannot pay that fee; that is the individual's responsibility.

Other doctors are perturbed when asked to complete medical reports for individuals whom they may not have seen for years. In these cases, however, the physician is not expected to describe the present condition of the patient, but the course of the disease and his medical condition as of the time he made his last examination, for the early history and clinical findings are needed to arrive at an equitable date of onset of a disability and provide evidence of chronicity.

Evaluation of Disability

The central purpose of disability evaluation is to determine remaining mental and physical capacities. To determine: (1) what the claimant

has left, and (2) what he can do with what he has left.

A realistic evaluation of disability must be based on clinical and laboratory tests of the individual's ability to meet the physical and mental demands of activity, to reason, to perceive, co-ordinate, and to perform certain basic activities such as sitting, standing, bending, walking, and manual function. When incapacity results from severe impairment of one or more such functions, it is essential to establish not only the fact that functional impairment exists, but also its extent.

A brief discussion of disability from heart disease may serve to illustrate the kind of evidence needed to measure the patient's remaining functional capacity, after appropriate therapy. Most frequently, impairments of the circulatory system produce loss of bodily function by reduction of cardiac reserve, or interference with peripheral vascular circulation. As a result the circulatory apparatus cannot meet effectively the metabolic demands placed upon it. The diagnosis of the condition usually reflects whether the impairment is caused by valvular disease, myocardial damage, or vascular pathology.

Cardiac size by x-ray or percussion, auscultatory findings and EKG findings furnish objective proof of cardiac pathology. The amount of dyspnea or angina described in terms of the number of steps that can be mounted or distance in feet or blocks that the patient can walk is highly significant to evaluation of the degree of loss of function. The presence or absence of cardiac edema and response to therapy are also indicative of severity of cardiovascular impairments. The status of the pulse in the peripheral vessels may provide gross clinical evidence of impaired circulation of the extremities.

Impairments of the cardiovascular system may manifest themselves with dramatic suddenness, e.g., myocardial infarction, obstruction of vessels in peripheral or central nervous system, circulation, lungs, and other visceral organs. The initial clinical manifestations are severe and the prognosis dubious. With survival from the acute stage, and appropriate therapy, substantial improvement can be expected over a period of time. A realistic evaluation of remaining function should be made after the convalescent period. Hence, the clinical and laboratory findings after maximum improvement from treat-

ment are particularly valuable in making a determination of remaining cardiac, brain or other function. (Note that a "waiting period" is prescribed by law, i.e., the first monthly disability insurance benefit cannot be paid until the seventh month after the onset of the disability.) A description of the acute attack helps confirm the diagnosis and should, therefore, be included in the report.

Loss of function is evaluated on the basis of clinical and laboratory findings *after maximum benefit* from treatment. Clinical information concerning nature and response to treatment furnishes information on stability of functional capacity, i.e., a history of periodic decompensated heart disease, in spite of treatment, would indicate a comparatively severe condition.

More complicated tests of vascular function may be required in certain cases, e.g., arteriography. The reporting physician should not be concerned because he may not have equipment to perform these tests. A carefully performed exercise tolerance test (if not medically contraindicated) will almost always provide the clinical evidence needed to evaluate the degree of remaining function.

Conclusion

In developing evaluation guides for the use of state agencies and its own technical and professional personnel, the social security administration has had the continuing co-operation of a medical advisory committee composed of recognized specialists associated with medical and allied professions in various fields outside government, such as general practice, research, medical education, industry and labor. Local medical policies in Arizona, such as fees paid for various examinations, are controlled by advice of the professional advisory committee of the division of vocational rehabilitation. This committee has been recognized and approved by the Arizona Medical Association.

The American Medical Association has taken steps to inform its members about the medical aspects of the disability program, especially the preparation of medical reports. On June 1, 1957, the Journal of the American Medical Association carried a comprehensive report on the administration and organization of the disability provisions. Regulations on the meaning of disability appeared in the Sept. 28, 1957, issue.

PROGRESS REPORT FROM THE ARIZONA POISONING CONTROL INFORMATION CENTER AT THE UNIVERSITY OF ARIZONA COLLEGE OF PHARMACY SALICYLATE POISONING

A RECENT report from the Boston Poison Information Center and the Boston Children's Medical Center presents a life saving method for the treatment of severe salicylate poisoning. The following case history was extracted from this report and is presented here to illustrate the treatment:

R. D., a two-year-old boy, accidentally drank an unidentified amount of oil of wintergreen on a Sunday afternoon. That night he was admitted to a hospital near New York City, where gastric lavage was performed, and he was then taken to his home near Pittsfield, Mass. On the following morning, fever, hyperventilation and unconsciousness developed. On admission, the temperature was 107° F., and the carbon dioxide combining power of the blood was 13 vol. per cent. After an initial intravenous infusion of one-sixth molar sodium lactate produced no improvement, an exchange transfusion of 1,000 ml. of whole blood was performed, through a cutdown on the right femoral vein. After the procedure he improved markedly and over the next two days, with continued intravenous administration of molar lactate, made a complete recovery.

MEPROBAMATE TOXICITY

Severe side effects of the allergic or hypersensitivity type occasionally follow ingestion of meprobamate. The most commonly reported reaction is the appearance of a rash, often within a few hours of a single 400 mg. tablet. The rash is usually erythematous and pruritic, but may be purpuric, urticarial, or maculopapular. The groin, axillae, inframammary areas, trunk, thigh, and arms are most commonly affected. Temperatures of 101-104° F., nausea and vomiting, pain or swelling of the joints and hypotension often accompany the rash. A white blood cell count of 11,000 to 12,000 has been noted with an increase in the proportion of polymorphonuclear cells and an eosinophilia of 4 per cent to 6 per cent. In several of the reported cases in which purpura has been a common feature, there have been positive capillary fragility tests, with normal platelet counts, bleeding times, and coagu-

lation times. In all reported cases the symptoms have cleared in one to seven days either spontaneously or following treatment with antihistamines or adrenocortical steroids.

Several clinical cases of massive overdosage in amounts ranging up to 40 Gm. have been reported. Poisoning is characterized by coma, occasional muscle twitching, and vasomotor and respiratory collapse. Symptomatic and supportive treatment, including respiratory and vasomotor stimulants, is recommended. In one case of overdosage from this drug, intravenous levarterenol (Levophed) and cerebral electrostimulation proved effective in overcoming the existing respiratory and vasomotor collapse.

**STATISTICS OF 92 POISON CASES
REPORTED SINCE THE OCT. 1, 1958
PROGRESS REPORT:**

Age:	Per Cent	Number
Under 5 years	81	(74)
6 to 15 years	1	(1)
16 to 30 years	10	(9)
31 to 45 years	5	(5)
Over 45 years	1	(1)
Not reported	2	(2)
Nature of incident:		
Accidental	86	(79)
Intentional	14	(13)
Outcome:		
Fatal	0	(0)
Recovery	100	(92)
Time of day:		
Between 6 a.m. and noon ..	37	(34)
Between noon and 6 p.m. ..	36	(33)
Between 6 p.m. and midnight	19	(17)
Between midnight and 6 a.m.	3	(3)
Not reported	5	(5)
Causative agents:		
Aspirin preparations	41.3	(38)
Sedatives (barbiturates, Doriden, Carbital, Compazine)	11.9	(11)
Other medication (Diuril, Chlorthrimeton, nose drops, cough syrup, Ex-lax, Butazolidin, etc.	10.9	(10)
Solvents (kerosene, gasoline, paint thinner)	11.9	(11)
Insecticides (Gator Roach Hive, chlordane, p-Dichlorobenzene)	5.5	(5)
Miscellaneous (Pride furniture		

polish, Arrid deodorant,
food poisoning, castor
beans, oleanders, etc. 10.9 (10)

Household bleaches and
disinfectants (Chlorox,
Pine-Sol, Lysol, Drano) .. 7.6 (7)

**DECEMBER 1, 1958, PROGRESS REPORT
FROM THE ARIZONA POISONING
CONTROL INFORMATION CENTER
AT THE UNIVERSITY OF ARIZONA
COLLEGE OF PHARMACY**

**Imported Voodoo Dolls Potential Hazard
to Public Health**

THE National Clearinghouse for Poison Control Centers has received word that Haitian voodoo Dolls carved from cashew nut shells imported and sold in this country as novelties and beverage "swizzle sticks" can have harmful effects on persons handling them. Analysis of the dolls revealed that the cashew nut shells contain an oily liquid and that its phenol-like quality can cause a severe contact dermatitis. The eyes of these dolls are believed to be Jequirity beans. These beans, which contain a toxic albumin, are as toxic as castor beans.*

The voodoo doll consists only of the cashew nut head and straw hat mounted on a 6-inch wooden stirring rod. A substantial number of the dolls have been used in this country. It is known that they are available in stores in certain Arizona cities. As these dolls continue to be purchased, it is hoped that adults will be urged to exercise extreme caution in the manner in which they use them, and furthermore that these dolls will be kept out of the reach of children.

**TOXICITY OF CERTAIN CHRISTMAS
DECORATIONS**

A timely consideration at this time of the year was the potential toxicity of certain Christmas decorations which could become involved in accidental poisoning in children when used around the home during the Christmas holiday season. The National Clearinghouse for Poison Control Centers has recently issued the following information:

(a) Christmas Tree Bubbling Fluid:

A few cases of ingestion of Christmas tree bubbling fluid by children have been reported

*Further information on the degree of toxicity and treatment of poisoning from Jequirity beans can be found in the Poison Control card file provided for each of the 18 Arizona Hospital Poisoning Control Treatment Centers.

in the past. The bubbling fluid is usually methylene chloride, each decoration containing 3 to 4 ml. of this liquid. Methylene chloride can cause central nervous system depression preceded or followed by CNS excitation. The estimated lethal dose of this substance is 0.5-5.0 ml/Kg. Toxicity can occur from inhalation or ingestion.

In the event that Christmas tree bubbling fluid is ingested, it is recommended that the stomach be emptied as soon as possible following ingestion. Further treatment is then symptomatic and supportive and will probably be directed toward central nervous system manifestations.

(b) Fireplace colors:

A group of potentially toxic substances sometimes used in homes at Christmas time are fireplace colors. These substances are metallic salts which, when thrown into a blazing fire, will bring forth variously colored flames, their diversity resulting from the burning of different metallic compounds. The toxicity of most of these substances ranges from moderate to extreme. A list of the metallic salts and the colors produced when they are burned may be found in Gleason, Gosselin and Hodge, "Clinical Toxicology of Commercial Products," page 1101.

It is recommended that, in the event of ingestion of any of these fireplace colors, the stomach be emptied as soon as possible following ingestion. Further treatment, if necessary, should then be directed toward the specific compound ingested.

(c) Christmas Tree Snow:

In addition to the above information on Christmas decorations supplied by the National Clearinghouse for Poison Control Centers, the textbook, "Clinical Toxicology of Commercial Products" reports the constituents and toxicity of artificial snow aerosol sprays used on Christmas trees, windows, etc. The ingredients consist of Freon, Lucite, and methylene chloride, the latter of which is the toxic ingredient. The toxicity and treatment of poisoning from this chemical agent is discussed above.

The Arizona Poisoning Control Information Center received a report of accidental ingestion by a child of an unknown quantity of the decoration, "Christmas Glitter," in December 1957. No ill effects apparently resulted. The manufacturer of this product was contacted for information concerning the active ingredients and

toxicity, if any. The manufacturer's reply was simply, "Glitter is metallic, not chemical!"

**STATISTICS OF 41 POISON CASES
REPORTED SINCE THE NOV. 1, 1958
PROGRESS REPORT:**

Age:	Per Cent	Number
Under 5 years	53.7	(22)
6 to 15 years	9.7	(4)
16 to 30 years	9.7	(4)
31 to 45 years	7.3	(3)
Over 45 years	14.7	(6)
Not reported	4.9	(2)
<i>Nature of incident:</i>		
Accidental	78.0	(32)
Intentional	22.0	(9)
<i>Outcome:</i>		
Recovery	100	(41)
Fatal	0	(0)
<i>Time of day:</i>		
Between 6 a.m. and noon ...	17.0	(7)
Between noon and 6 p.m. ...	46.4	(19)
Between 6 p.m. and midnight	22.0	(9)
Between midnight and 6 a.m.	2.4	(1)
Not reported	12.2	(5)
<i>Causative agents:</i>		
Poisonous gasses (carbon monoxide)	19.4	(8)
Sedatives (barbiturates, Equanil, Sleep, Doriden)	17.0	(7)
Aspirin preparations	14.7	(6)
Other medication (thyroid, aminophyllin, camphorated oil, Mol Iron)	14.7	(6)
Solvents (turpentine, kerosene, lighter fluid, nail polish remover)	14.7	(6)
Household cleaners, oxydol, ammonia, air deodorizer ..	7.3	(3)
Botanicals (gourds)	4.9	(2)
Food poisoning	4.9	(2)
Insecticides (moth balls) ...	2.4	(1)

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BONADOXIN[®]

(tablets and drops)

**STOPS
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MORNING
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BONADOXIN Tablets relieve nausea and vomiting of pregnancy in 9 out of 10, 7 often within a few hours.

Moreover, a controlled study of 620 cases reported that with BONADOXIN "toxicity and intolerance" (are) zero. BONADOXIN is rarely soporific. It is free from the risks associated with overpotent tranquilizer-antinauseants.

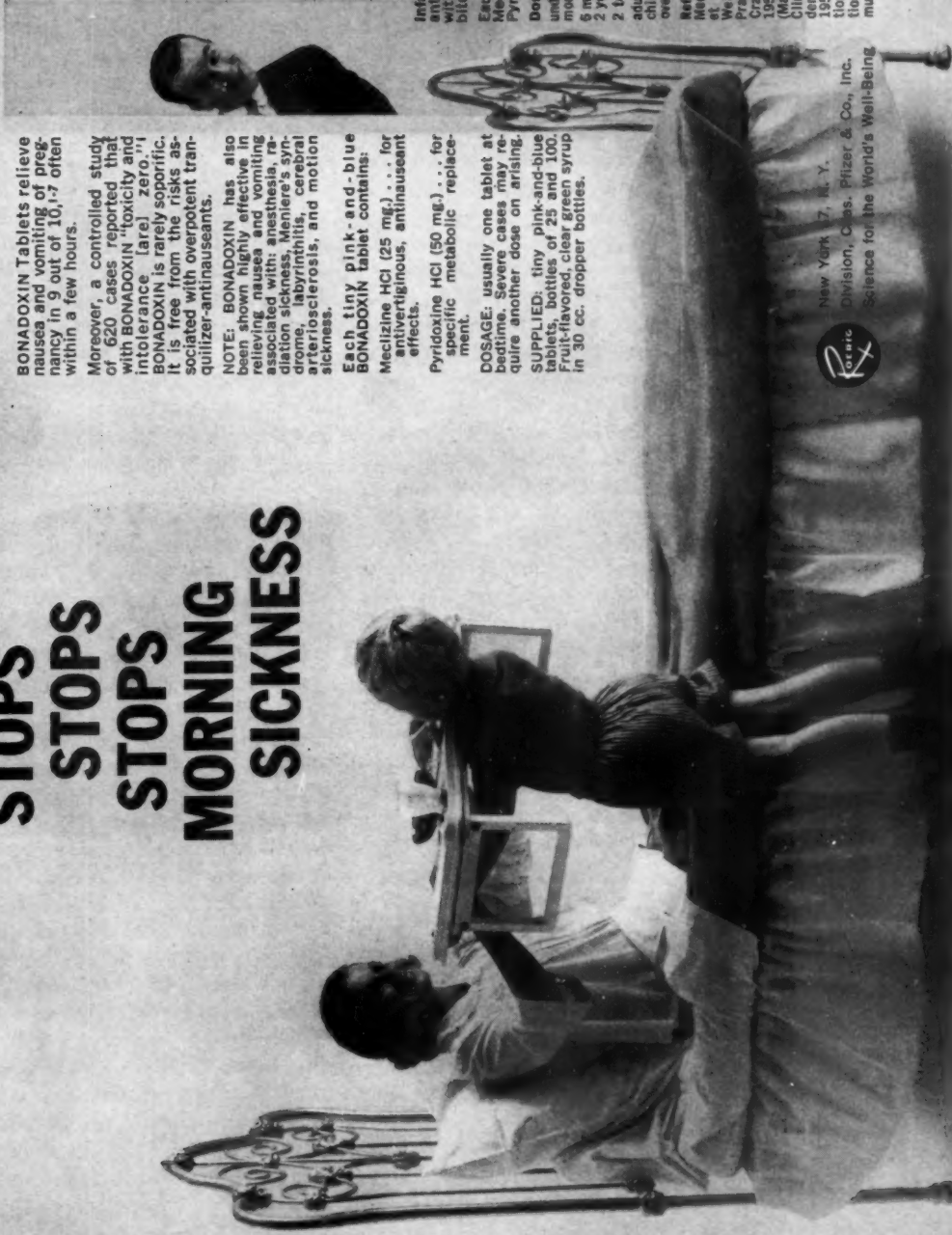
NOTE: BONADOXIN has also been shown highly effective in relieving nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis, and motion sickness.

Each tiny pink-and-blue BONADOXIN tablet contains: Meclizine HCl (25 mg.) . . . for anti-vertiginous, antinauseant effects.

Pyridoxine HCl (50 mg.) . . . for specific metabolic replacement.

DOSAGE: usually one tablet at bedtime. Severe cases may require another dose on arising.

SUPPLIED: tiny pink-and-blue tablets, bottles of 25 and 100. Fruit-flavored, clear green syrup in 30 cc. dropper bottles.



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Science for the World's Well-Being

Infant celiac? BONADOXIN DROPS are antispasmodic...stop colic in 84% of cases without the risk of belladonna and biliturates.

Each cc. contains:
Meclizine dihydrochloride . . . 8.33 mg.
Pyridoxine hydrochloride . . . 16.67 mg.

Dosage:

under 6 months 0.5 cc.
6 months to 2 years 1.5 to 2 cc.
2 to 6 years 3 cc.
adults and children over 6 1 tsp. (5 cc.)

2 or 3 times daily, on the tongue, in fruit juice or water

References: 1. Goldsmith, J. W.: *Minnesota Med.* 40:99 (Feb.) 1957. 2. Grosklos, H. H., et al.: *Clin. Med.* 2:885 (Sept.) 1955. 3. Weinberg, A., and Werner, W. E. F.: *Am. J. Obst. & Gynec.* 6:580 (April) 1955. 4. Cramer, J. C.: *Am. J. Obst. & Gynec.* 1956. 5. Tarloff, G.: *Am. J. Med.* 1953 (March) 1955. 6. Dunn, R. D., and Fox, L. P.: *Clinical exhibit* 7. Gooding, J. W., and Lowden, R. J.: *Northwest Med.* 57:331 (March) 1958. 8. Dougan, H. T.: Personal communication. 9. Leonard, C. L.: Personal communication. 10. Steinberg, C. L.: Personal communication.

GOVERNMENTAL ACTION RELATED TO MEDICINE

A. Plan Drawn Up for Action on Keogh Legislation.

A PLAN of action to obtain passage next year of the Keogh bill has been approved by the executive committee of the American Thrift Assembly and presented to the assembly's board. ATA already is at work contacting candidates for senate and house.

ATA was formed by a number of professional groups interested in the legislation, including the AMA. The bill would allow the self-employed to defer income taxes on a certain percentage of their earnings if placed in retirement plans.

The blueprint for operations next year was drawn up by a special committee appointed by ATA's executive committee. Active in the work were Dr. William J. Kennard, representing the AMA; Milton F. Lunch, National Society of Professional Engineers; Donald E. Channell, American Bar Association; Lyman Bryan, American Institute of Certified Public Accountants; and Al Payne, National Association of Real Estate Boards. Sending the proposed plan to members of ATA's board, ATA Chairman F. Joseph Donohue wrote:

"The favorable action on the bill in the last session raises our hopes for complete success in the coming session of the congress. The discussion of this measure on the floor of the house prior to its passage, as well as the later debate on the floor of the senate before it was ruled 'out of order' as not 'germane' to the bill to which it was sought to be attached by way of amendment by Senator Potter, has pointed to our areas of strength and to our areas of weakness. It is on the latter we hope to concentrate."

B. 138 Papers Read in Three-Day Symposium on Antibiotics.

Almost 1,000 physicians and others interested in antibiotics gathered in Washington for a three-day symposium and heard more than 138 papers presented. In addition, titles of 43 others (which will be published in the 1958-59 Antibiotics Annual) were read.

The previous five meetings were jointly sponsored by the U. S. Food and Drug Administration and the publications Antibiotics & Chemotherapy and Antibiotic Medicine & Clinical

Therapy, but this year the publications sponsored the symposium alone. Chairman was Henry Welch (Ph.D.), director of FDA's division of antibiotics. In the opening talk, Dr. Welch pointed out that tremendous quantities of antibiotics now are being produced (more than 2.5 million pounds a year).

Heavy emphasis was placed on what Dr. Welch described as the "pressing problem" of the antibiotic resistant staphylococci and the consequent prevailing world-wide incidence of staphylococcal disease. Four sessions of the symposium, including two panel discussions, were devoted almost exclusively to this problem.

Speakers included Sir Howard Florey, who brought penicillin from England to the U. S.; Dr. Selman Waksman, in whose laboratory streptomycin was discovered; Dr. Chester Keefer, who organized and administered the first clinical programs for both penicillin and streptomycin; and Dr. Harry Dowling, prominent internationally in chemotherapy and particularly broad-spectrum therapy.

A feature of the symposium was presentation to the Smithsonian Institute of the original soil sample from which aureomycin was derived. Present was one of the first patients on whom the drug was used, Mrs. Louise M. Ellis of Suffolk, Va.

C. Survey Shows Radiation in Most Foods Not 'Significantly High'.

A two-year survey of a variety of samples of foods produced since 1945, when atomic and hydrogen bombing and testing began, shows "most of them do not carry significant burdens of radioactivity." Certain seafoods, dairy products and tea were exceptions, but even with them there is no danger as commonly consumed. Ratings were made by comparing the foods with similar samples produced prior to 1945. The assumption was that the level of "natural" radiation would be the same before and after 1945, when "man-made" radiation started appearing in the form of fallout.

The study was carried out by the food and drug administration and described to the Washington meeting of the Association of Official Agricultural Chemists by Edwin P. Laug and Wendell C. Wallace. The findings:

Vegetables — No significant increase in radioactivity since 1945 for all samples studied, po-

tatoes, corn, beans, peas, beets and turnips, carrots, spinach and miscellaneous.

Fruits — No significant increase in any samples, pears, cherries, peaches, apricots, plums, tomatoes and tomato products, berries, fruit juices and miscellaneous.

Seafood — No increase trend whatever for shrimp, lobster and crabs. Fish varieties and oysters and clams "exhibited a trend toward higher radioactivity." Individual shellfish values showed "a significant rate of increase when plotted by years since 1944."

Dairy Products — (Chiefly fresh fluid milk, evaporated milk, milk powder and cheese) "Statistically significant increase in total radioactivity shown."

Tea — The largest increase noted in these products. Samples, chiefly from 1956 and 1957 harvests, "showed radioactivity that averaged about 30 times greater. It could therefore be possible that many of the tea samples examined contained strontium 90 in excess of the present tolerance of 80 micro curies per kg., but analysis of strong tea brews revealed that only about 17 per cent of the radioactivity was extracted (from the leaves). It can be concluded therefore that the beverage as commonly consumed would not contain over-tolerance amounts of strontium 90."

Miscellaneous — No increase in radioactivity for meats, wheat, sugar and jams, bread. Cocoa and cocoa beans had relatively high count, but there were no pre-1945 samples for comparison, so this could not be attributed to man-made fallout.

D. Only \$4 Million Remains of Research Facilities Grant Fund.

With award by Public Health Service of 98 grants worth \$13 million, only about \$4 million now remains of this fiscal year's \$30 million fund. The first \$13 million was awarded in August. Awards are made on recommendation of the National Advisory Council on Health Research Facilities, which in September approved the grants just awarded.

Since the inception of the program, it has awarded a total of 441 grants totaling almost \$90 million. Money goes to both public and non-profit hospitals, medical schools and other research institutions. Recipients must put up at least as much for the projects as the U. S. grants.

Largest in the latest list of awards is \$2,040,935

to Tulane University for construction of a medical research addition. Other large grants were \$1 million to Chicago Medical School for a research building, and \$750,000 to the University of Chicago for a biological science research building.

E. Personnel: Appointments for General Niess, Drs. Dearing and Hyde.

On Dec. 1 Maj. Gen. Oliver Niess took over as air force surgeon general, succeeding Maj. Gen. Dan C. Ogle, who is retiring after almost 30 years of service. General Niess, now command surgeon of the Pacific air forces in Hawaii, was instrumental in setting up a medical care program for U. S. nationals throughout Southeast Asia. General Ogle was instrumental in establishing the Aeromedical Research Center at Brooks Air Force Base and constructing 170 new medical facilities in many parts of the world.

Dr. W. Palmer Dearing, on loan from public health service, has been made director of health services for the new Office of Civil and Defense Mobilization, formed by the merger of the office of defense mobilization and the federal civil defense administration. Dr. Dearing was assistant administrator for health affairs in the former.

Dr. H. Van Zile Hyde has been made assistant to the surgeon general of public health service for international health and will be the surgeon general's chief advisor on all international health affairs. His responsibility will include liaison with the state department and other agencies concerned with international health. Dr. Hyde, who has been chief of the division of international health for the last five years, will continue to represent the U. S. on the executive board of World Health Organization.

Dr. C. J. Van Slyke, since 1952 an associate director of the National Institutes of Health, will become deputy director of NIH.

Dr. Kenneth M. Endicott, now chief of the Cancer Chemotherapy National Service Center at NIH, has been named an associate director, responsible for training and activities of the institutes' eight operating programs.

Richard L. Seggel, now head of the office of management policy in the department of health, education, and welfare, will shift to the NIH as executive officer.

Drs. Van Slyke and Endicott and Mr. Seggel will be on the immediate staff of Dr. James

A. Shannon, director of the institutes. They will take their new posts in the next several weeks.

The new director of the army's office for dependent's medical care (Medicare), Col. Floyd L. Wergeland, has been promoted to brigadier general.

Dr. Philip Handler, professor and chairman of the department of biochemistry and nutrition at Duke School of Medicine, has been appointed to the National Advisory Health Council, one of nine that advises public health service on its medical and research programs.

F. NIH Awards \$20.7 Million in Grants in Month.

In September, the National Institutes of Health awarded \$20.7 million in grants and fellowships, with all but \$581,369 going for grants. Grants went to 1,398 scientists and institutions, fellowships to 150 individuals. Forty-seven per cent of the grant money was for research in arthritis and metabolic diseases.

G. State Health Officers Told of Long-Range Health Planning in HEW.

In an address to the Association of State and Territorial Health officers, Secretary Flemming disclosed he was considering some long-range studies on national health objectives. While still in discussion stage, it is understood the planning may take the form of another Bayne-Jones type of report. This study, released last summer by a group of consultants to the secretary of HEW, proposed major advances in spending for medical research and education.

Asked about the level of Hill-Burton hospital construction spending for the next fiscal year, Mr. Flemming recalled that the record high total of this year (\$187 million) was voted as an anti-recession move, and that economic conditions have improved.

Dr. Leroy Burney, PHS surgeon general, reported: (1) Asian influenza outbreaks can be expected again this winter but probably with fewer cases; a new polyvalent vaccine has been developed for the disease, (2) PHS hopes to have bids out and ground broken by spring on the \$6.9 million National Library of Medicine building at Bethesda, Md.

H. Public Campaign for Polio Vaccinations Resumed this Winter.

The public health service has decided to resume the public educational program aimed at getting more people inoculated with the Salk poliomyelitis vaccine. The reason is that the

drive of last winter and spring has fallen short of expectations. In the words of Secretary Flemming, "... we have not made nearly the progress we could and should have made during the year — a year in which for the first time there was no shortage of vaccine at any time in any area."

Upshot is that the advertising council will again carry out a promotion campaign, with the co-operation of the American Medical Association, the national foundation, state and local health departments and private groups.

Surgeon General Burney of public health service made a report on the 1958 polio season with these highlights:

Of the population under age 40, about 53 per cent has not had the basic three injections, and over a third has had no vaccine at all. There were 1,815 cases of paralytic polio during the first nine months of the year, 258 more than in the same period in 1957.

Cited as a disturbing factor was that in six states (Michigan, New Jersey, Virginia, Texas, West Virginia and California) the majority of paralytic cases, 416 out of 781, were among children under five. Of these 416, four out of five had had no vaccine.

There is mounting evidence that incidence of polio is increasing in lower socio-economic groups. Mr. Flemming blames this on apathy, not any "insurmountable financial obstacles." He pointed out funds were available from a number of sources and that the AMA has encouraged state and local societies to organize community clinics and provide vaccinations at minimal cost.

The increase in the number of paralytic cases is no reflection on the efficacy of the vaccine. During the three and a half years of use, effectiveness rate has held at between 60 and 90 per cent. Nor is there any evidence that properly vaccinated persons are losing their immunity.

Both Mr. Flemming and Dr. Burney expressed doubts over the need for any compulsory program of vaccinations for polio.

I. IRS Rules on Nursing Home Care for Mentally Retarded.

The internal revenue service has ruled that expenses incurred by a taxpayer for maintaining his mentally retarded son in a home that cares for such cases and was recommended by a physician constitute medical expenses, and are deductible. The patient suffered from brain

damage in childhood and at age 13 was so severely disturbed that his doctor concluded it was neither safe nor practical for him to remain with his parents.

IRS regulations provide that the cost of in-patient hospital care including costs of meals and lodgings is an expenditure for medical care. The agency holds now that a private institution which is regularly engaged in providing medical care is considered an institution for purposes of regulations. "For example," IRS said, "medical care includes the entire cost of institutional care for a person who is mentally ill and unsafe when left alone." The child, in this case, has a chance to make a marginal adjustment, IRS said.

J. Doctors, Medical Societies Urged to Aid State Motor Officials.

The physician in charge of special health services for the public health service wants state medical societies and private physicians to lend a hand to motor vehicle directors in finding out why 40,000 Americans are killed by autos each year. Dr. A. L. Chapman told the annual meeting of the Association of State and Territorial Health Officers that while medical scientists have been successfully confining malaria and polio, relatively little has been spent in determining the basic reasons for the high annual highway toll.

"To me this is a challenge which has been inexcusably evaded by the rank and file of the public health and medical professions for several decades. The question now is, what are we going to do about it?"

Dr. Chapman suggested: (1) Responsibility for advising state motor vehicle administrators on criteria that can be used to limit driving privileges of those suffering from diseases making them high risk drivers is clearly a medical responsibility. The state health department should bring the medical society and private doctors into the picture.

(2) There is a vast field of study and investigation by medical and paramedical personnel, such as effect of emotions on driving ability, personality pattern of chronic traffic violators and motivations of those who drive in an irresponsible fashion.

(3) Educational programs to get over to the driving public the effects of drugs such as antihistamines on driving ability; the effects of alcohol on reflexes and judgment, and the effect of fatigue on reaction time.

K. Six Drug Firms Deny Charges of Antibiotics Monopoly, Ask Dismissal

The six pharmaceutical firms cited last July by the Federal Trade Commission on monopoly and price charges in producing tetracycline antibiotics have denied the charges and formally asked FTC to dismiss the complaint. FTC claimed that Charles Pfizer & Co. made misleading statements in applying for a government patent on tetracycline; the company, in turn, issued licenses to five other firms for production. They are American Cyanamid, Bristol-Myers Co., Bristol Laboratories Inc., Olin Mathieson Chemical Corp. and Upjohn Co.

American Cyanamid, in its formal reply to FTC, argued that a patent issued by the patent office is presumed to be valid. They said that licensing arrangements between Pfizer and the others made it possible for the firms to compete vigorously in the sale of tetracycline. Pfizer maintained that the complaint covers alleged offenses outside FTC jurisdiction.

L. One New Physician In Congress; Dr. Morgan Heads Foreign Affairs

Physician members of the 86th congress number four, one less than the last congress. Back are Drs. Walter Judd of Minnesota, Thomas Morgan and Ivor Fenton, both of Pennsylvania, and one newcomer, Dr. Thomas Alford of Arkansas. Defeated were Drs. Will Neal of West Virginia and A. L. Miller of Nebraska. Dr. Neal had been active on the health subcommittee of the house interstate committee and Dr. Miller on District of Columbia and interior and insular affairs committees.

Dr. Alford, a board ophthalmologist of Little Rock, ran for public office for the first time. He is 42 and has had an active practice. Son of a public school administrator, Dr. Alford was educated in Arkansas schools and received his medical degree from the University of Arkansas. He interned at Oklahoma City, spent his residency in Chicago and was assistant professor of ophthalmology at Arkansas before serving during World War II in the army medical corps. He has been practicing in Little Rock since 1948.

Dr. Morgan is scheduled to take over the chairmanship of the house foreign affairs committee on which Dr. Judd also serves. Dr. Morgan would become the first physician to head that important committee in its 136 years.

M. Congressional Elections And Probable

Effect On Medical Legislation

An analysis of the probable fate of medical legislation during the 86th congress is in order. Top-heavy Democratic majorities in both the house and senate make policy decisions of the Democratic leadership of key importance in medical as well as all types of legislation. Equally important, the make-up of all committees is markedly altered.

In the senate, for instance, when the margin was 49 Democrats to 47 Republicans, senate committees were closely divided. With the Democrats picking up a record gain of 13 seats in the senate, committee composition has changed. (Under the Reorganization Act of 1946, each senator is assured of two committee assignments).

Legislation rarely gets to the floor for a vote unless some committee sends it there. Majority policy some times becomes stalled when a committee, for various reasons, finds itself in disagreement with that policy.

Selections to committee are made differently in each house and by the parties. In the senate, the Democrats make appointments through the 15-man steering committee headed by Majority Leader Lyndon Johnson; other members are, Mansfield, Hennings, Chavez, Ellender, Frear, Russell, Hayden, Holland, Humphrey, Pastore, McClellan, Robertson and Johnston (S.C.). The Republicans in the senate use a five-man committee on committees that was made up in the 85th congress of Senators Knowland, Bricker, Saltonstall, Bridges and Dirksen. In the house, the Democratic committee on committees is made up of all Democratic members of the ways and means committee. The Republicans' committee on committees is made up of one member for each Republican state delegation and with House Minority Leader Martin as chairman. With this background, let's examine the composition of committees in both houses which are most concerned with medical legislation.

House Ways and Means

A committee of major importance to physicians is the house ways and means committee under Chairman Wilbur Mills (D., Ark.). Its membership for several years has been divided 15 Democrats to 10 Republicans. In the 86th congress, the committee will be considering legislation that would impose, on a compulsory basis, hospitalization and medical care benefits for retired social security recipients and their

dependents. The committee also is expected to consider amendments to public assistance laws which in large measure are evolving into medical programs for the indigent. Keogh legislation to permit self-employed persons to establish annuities with deferred taxes will again be considered by ways and means.

At least seven members of the former committee are not serving in the new congress. Their loss to the committee can be attributed to one death, a decision by four not to seek re-election to the house, and defeat of two. The men who succeed these seven could shape the entire philosophy of the committee.

Senate Finance Committee

In the senate, the finance committee is of importance to the medical profession. It is the counterpart to the ways and means committee in the house. Its chairman is Sen. Harry Byrd (D., Va.).

This committee has been considered in the past to be a middle-of-the-road group. With the appointment of new members, both Republican and Democratic, this group's attitude on health legislation could be altered.

House Interstate and Foreign Commerce Committee

Another committee of importance is the house interstate and foreign commerce committee, under chairmanship of Rep. Oren Harris (D., Ark.). For several years, it has been made up of 18 Democrats and 15 Republicans. In the new congress, the committee will be considering such matters as amendments to the Hill-Burton Hospital Construction Act, federal aid to medical schools, expanded medical research programs and food and drug legislation.

Senate Labor and Public Welfare Committee

A fourth important committee to physicians is the senate labor and public welfare committee whose chairman is Sen. Lister Hill (D., Ala.). This committee handles major health legislation, and in addition has jurisdiction over some veterans' matters where medical interest is involved.

N. HEW Secretary Explains Long-Range Health Goals Study

Secretary Flemming has outlined more specifically his ideas on a long-range study of the country's health, welfare and education goals and a spelling out of what should be the fair share of the government. The HEW secretary told a press conference: "I am tired of people pulling figures out of the air on what the fed-

eral government ought to do. There is no recognition of state, local and private responsibilities. All have to share."

His plans for a health survey contemplates a group of consultants along the lines of the Bayne-Jones committee which reported last summer on needs and goals in medical research and medical education. He promised full consultation with interested organizations in seeking answers to the following: (1) The time span for achieving goals, (2) How much to be spent each year and, (3) Extent of spending through grants-in-aid.

O. Two Meetings With National Groups On Rehabilitation And Education

The first two in a long series of discussion sessions with heads of an eventual 400 national organizations concerned with health, education, and welfare were held the week of Nov. 3. Secretary Flemming has described them as "listening" sessions, to gather impressions on national and regional problems. The first was on vocational rehabilitation, the second on higher education exclusive of medical education.

Among proposals aired at the vocational rehab meeting were: (1) Creation of a new federal agency for training the severely handicapped for independent living when they cannot return to employment, (2) Establishment by the federal government of a program for rehabilitating between 500,000 and 750,000 who are jobless because of alcoholism, (3) A suggestion that workmen's compensation boards in each state rehabilitate the disabled and not just pay them compensation.

P. New Plans For National Library of Medicine

Public health service has submitted preliminary plans for construction of the \$7 million National Library of Medicine to the General Services Administration's public buildings service. The latter must okay all plans for federal construction. PHS says the buildings will be of five stories and of 232,000 square feet, with three floors below ground level. Ground will be broken at Bethesda, Md., in the spring, and completion due in 1961, the 125th anniversary of the library's founding.

Q. Miscellany:

The three physicians who won the Nobel prize for medicine and physiology, according to HEW, have been closely associated for many years with research supported by the National Insti-

tutes of Health. They are Drs. Edward Tatum of the Rockefeller Institute of Medical Research, George Beadle of the California Institute of Technology and Dr. Joshua Lederberg of the University of Wisconsin. The office of vocational rehabilitation has made a grant of \$5,300 to the National Rehabilitation Association to survey spending by private agencies for rehabilitation of the disabled. Secretary Flemming says the data is needed to determine what the government effort should be in this field.

R. Forand Proposal Now Third On Labor's Legislative Goals

The AFL-CIO has given high priority to passage of the Forand proposal for hospitalization and surgical services of OASI beneficiaries. It is now third on a 10-point legislative program. Ahead of it, according to President George Meany, are only aid to depressed areas and federal aid to general education. On the Forand bill, Mr. Meany states: "It is still either impossible or too costly for our senior citizens to obtain such insurance through non-profit or commercial channels."

Legislative goals were outlined at a press conference. Mr. Meany observed in a statement: "The American people on Nov. 4 very emphatically indicated that they do not agree with those political leaders who have little faith in the dynamic character of our national economy. By an overwhelming vote, they elected to congress new senators and representatives who want to forge ahead and properly utilize our nation's human and natural resources to build a better world for all. By the same vote, they retired many members of congress who have followed a stand-still policy."

The labor chief added that this was not the time to "raise false issues," but "the time to give the American people the program for which they have voted. . . ."

S. Medical Determinations For Disability Freeze Now 500,000

The social security administration's medical advisory committee has learned that slightly more than half of the initial determinations thus far considered under the three-year-old disability freeze have been allowed. At a meeting of the committee in Baltimore, it was shown that 1,081,600 applying for the freeze had gone through their medical evaluation since the law was passed. Of these, 572,800 or 53 per cent

have been allowed. The agency gave no figures on total applications received.

Secretary Flemming of HEW told the committee that it had successfully worked out a sound method of determining disability "in a way which does not interfere with doctor-patient relationships." Under the system worked out for determining whether the disability requirement is met, a person who applies for disability insurance benefits or seeks to have his social security record frozen is first asked to get a statement from his physician. The latter is asked to report clinical findings — the results of medical tests and lab exams. The decision whether a person is disabled is made by a team of trained people, including a doctor, in a state agency.

Members of the advisory committee include: Drs. J. Duffy Hancock, University of Illinois School of Medicine; Herman Hilleboe, New York state health commissioner; Leo Price, medical center, International Ladies' Garment Workers' Union, and member of the AMA committee on medical care for industrial workers; and Charles L. Farrell, president, Conference of Presidents and Other Officers of State Medical Associations.

T. Two Physicians On National Group For White House Youth Conference

Two of the 12 members named by President Eisenhower to the national committee for the White House conference on children and youth are physicians. The meeting, set for March 1960, has been held every 10 years since inaugurated in 1909 by President Theodore Roosevelt. The doctors are Edward D. Greenwood, co-ordinator of training in child psychiatry, Menninger Foundation, and Daryl P. Harvey, staff physician on the Howard Clinic, Glasgow, Ky. Other members include a newspaper editor, a college president, religious leaders and social welfare executives.

President Eisenhower will serve as honorary chairman, HEW Secretary Flemming as honorary vice chairman; Mrs. Rollin Brown, past president of the National Congress of Parents and Teachers, conference chairman, and Mrs. Katherine Oettinger, chief of the children's bureau, secretary. A White House announcement said the conference is designed to take stock of prospects of children and to bring attention and emphasis on policies and programs most effective in advancing their welfare.

U. Antibiotics Can Now Go Beyond Iron Curtain

Antibiotics and related drugs, long banned from shipment to Russia and satellite countries, can now be shipped there provided that individual export licenses are issued. Without giving any reason for the lifting of the ban, the department of commerce simply said that previously, except for research purposes and certain emergency situations, applications to export these commodities to the European Soviet bloc generally were denied. Relaxation does not apply to Communist China, North Korea and North Vietnam which are under total embargo from U.S. goods. Commodities include penicillin, streptomycin, dihydrostreptomycin, aureomycin, terramycin and all other similar antibiotics, including sulfonamides. Commerce decided that shipments to Poland can be made under a general export license.

V. Mental Health Needs Meeting Hears Pleas For More Federal Aid

Representatives of national organizations in the mental health field met in the third of Secretary Flemming's "listening" conferences. Again through the remarks ran the theme of need for more federal assistance. One conferee, Kenneth Williamson of the American Hospital Association's Washington office, commented that when there is talk of "federal leadership" it simply means "federal financing." Dr. Leo Bartemeier representing the American Medical Association, said that mental illness in this country was really an epidemic disease and must therefore have the assistance of the community, not just doctors. The federal government must also lend a hand, he said.

Dr. Julian Price, speaking for the joint commission on accreditation of hospitals, told the conference that mental hospitals are being judged the same as general hospitals on whether they are able to give good, complete care. He said he would like to see a psychiatrist named to the joint commission.

Dr. Robert Felix, chief of the National Institute of Mental Health, told of an average 120 per cent turnover annually in psychiatric and ancillary personnel in mental institutions. He advocated more training programs for ancillary groups. Dr. Francis Gerty, president of the American Psychiatric Association, strongly advocated an integration of mental hospitals with

communities, which would encourage volunteers to lend assistance and also aid discharged patients to return to their former environment.

W. Senate Unit On International Health Asks Aid Of Private Medicine

The senate government operations subcommittee studying international health operations is advocating in its first report increased teamwork of private medicine, allied groups and the pharmaceutical and chemical industries. Comments the report: "It is the hope of men of good will everywhere that more and more the energies of all nations may be channelled to the constructive purpose of furthering the well being of man. In this effort, increased teamwork is essential." It did not spell out details other than declaring:

"Medical research itself has always had an international character. Medicine has been the beneficiary of discoveries which have transcended national boundaries. Today the complexity and volume of medical research render especially important the promptest possible exchange of scientific information and strengthened co-operation. In this way, precious time and effort may be saved and used to best advantage."

X. Three New Regents Named To National Library Of Medicine

The President has named two doctors to the National Library of Medicine board of regents. They are Dr. William B. Bean, professor of medicine and head of the department of internal medicine, State University of Iowa College of Medicine, and Dr. William Stadel, a former hospital administrator and now director of the San Diego, Calif., Department of Medical Institutions. A third regent is Mrs. Eugenie Mary Davie of New York, chairman of the women's auxiliary of the New York Republican county committee. The regents elected as their chairman Dr. Champ Lyons, professor of surgery and head of the department of surgery, Medical College of Alabama. Dr. Lyons has been a regent since 1956; 1958 was his last year. He succeeds Dr. I. S. Ravdin whose term has expired. The regents at their first fall meeting also discussed plans for next spring's ground breaking for the \$7 million new building which is set for completion in 1961.

Y. PHS Sees Air Pollution As Disease Factor

Public health service states that it appears likely that the medical effects of air pollution

are not confined to the respiratory and circulatory systems. Epidemiological and statistical studies show parallels between air pollution and mortality rates from cancer of the stomach and esophagus, similar to those from lung cancer. PHS also made the point in its report that mortality rates for lung cancer among urban dwellers are significantly higher than among strictly comparable rural groups, smoking habits notwithstanding.

On the economic effects of air pollution, PHS said that it is quite apparent that the estimated third of a billion dollars now spent for prevention is out of line with the estimated \$4 billion spent for neglect. "More money put into the asset side would remove several times as many dollars from the debit side."

HEW listed some of the speakers for the conference which will review recent knowledge about air pollution and recommend future plans for dealing with the problems. PHS Surgeon General Burney and HEW Secretary Flemming head the list. Others are Senator Kuchel (R., Calif.), who sponsored legislation on federal pollution control; Dr. Herman Hilleboe, New York state commissioner of health; Dr. Malcolm H. Merrill, director, California Department of Public Health, and Gen. John E. Hull, president, Manufacturing Chemists Association.

Z. Substantial Drop In 10 Diseases Reported By PHS

Final figures of the National Office of Vital Statistics show substantial reductions in the incidence of 10 diseases during 1957 compared with the previous year. They are brucellosis, diphtheria, encephalitis, hepatitis, malaria, poliomyelitis, psittacosis, trichinosis, tuberculosis and typhoid fever. Polio cases in 1957 amounted to 5,485, the lowest since 1942 when the total was 4,167. Of the 1957 total, 2,499 were paralytic.

NOVS said there was little change in reported incidence of dysentery, rheumatic fever, tetanus, meningococcal infections and venereal diseases. A rise in the number of syphilis cases was noted, from 131,763 in 1956 to 136,039 in 1957. Previously there had been a steady decline.

A.A. Lost Or Strayed: 400,000 Social Security Eligibles

Social security administration is looking for about 400,000 persons who may be eligible for payments under the 1958 amendments to the so-

cial security law. The amendments extend benefits to many who were formerly denied and to others who are newly eligible. In many cases, SSA can neither identify nor locate the eligibles. Comments the agency: "To locate others would require a search through mountains of records."

**B.B. FEDERAL MEDICAL-HEALTH
SPENDING FOR FISCAL YEAR 1959**

(July 1, 1958 to June 30, 1959)

The federal government's medical activities are on a massive scale and they continue to grow. This year for all health programs (research, medical care, public health) Uncle Sam is spending about 62.6 per cent more than he did five years ago, 13.5 per cent more than last year. Programs in 22 separate agencies and departments of government range from cancer research to federal employe clinics. The total cost is \$2.8 billion, or \$344.7 million more than last year.

For six years now the Washington office of the American Medical Association, through this annual budget report, has charted this expanding course of federal medical activity, a service not performed by any other organization. We identify all programs, describe their purpose,

give their present appropriations, and note the amount of increase. We do not attempt to evaluate them — to rate them as good, bad, or indifferent; as wasteful or invaluable. This is a factual study, based on scrutiny of appropriation acts passed by the last congress and information supplied us by program and fiscal officers in the various departments and agencies, all of whom gave us their wholehearted co-operation. It covers the current fiscal year which ends next June 30.

While nearly 38 million people are eligible to receive all or part of their medical care from or through the federal government, medical care represents only a part of the total spent by the U. S. in medical fields. Many millions of dollars go for research, drug control, personnel training and other efforts not directly related to the rendition of medical care.

As in last year's report, we have listed in table form payments to disabled persons through programs which the federal government finances entirely or in part. Such beneficiaries now total nearly 6 million, a 15 per cent increase over last year. Money paid them has increased to \$4.75 billion, over 40 per cent more than last year.

**MEDICAL-HEALTH BUDGETS OF FEDERAL DEPARTMENTS
AGENCIES AND COMMISSIONS FOR THE FISCAL YEAR**

<i>Agency</i>	<i>Fiscal 1959</i>	<i>Fiscal 1958</i>
Department of health, education, and welfare	\$1,116,207,806	\$ 849,395,800
Veterans' Administration	843,524,000	849,374,000
Department of defense	751,115,000	702,305,000
Atomic Energy Commission	45,462,000	40,085,000
International co-operation admin.	39,600,000	37,300,000
Department of state	21,638,380	15,718,110
National Science Foundation	19,575,000	7,500,000
Office of Civil and Defense Mobilization	13,617,000	3,177,000*
Federal employes health programs	11,000,000	10,000,000
Department of labor	8,827,000	8,069,476
Panama Canal Co. and Panama Canal		
Zone government	3,959,900	5,988,300
Department of treasury	3,854,500	3,837,850
Department of justice	2,105,000	1,796,000
District of Columbia	2,000,000	3,700,000
Federal Trade Commission	1,600,000	1,500,000
Department of commerce	1,212,400	911,300
Civil service commission	426,000	387,000
President's comm. for employment of the	214,700	182,575

*The figure for fiscal 1958 is the appropriations of the federal civil defense administration and the office of defense mobilization; now combined in the Office of Civil and Defense Mobilization.

physically handicapped	150,000	70,000
Small business administration	140,000	154,950
Department of the interior	19,000	19,000
National advisory committee to selective service	13,145	12,145
Office of the attending physician of congress		
TOTALS	\$2,886,260,831	\$2,541,483,506

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

(This Year: \$1,116,207,806 —

Last Year: \$849,395,800)

Division of Hospital Facilities \$187,800,000

last year: \$122,650,000

This division administers the federal aspects of both the original and expanded Hill-Burton programs. In 1958, congress enacted legislation which authorized loans in lieu of grants for any of the eligible projects under the entire program. Since 1946 the federal contribution through June 30, 1958, amounts to \$1,024,000,000; when the sponsors' share is included, the total is \$3,323,000,000 (these figures are for both the original and the expanded program). This is the first time since fiscal 1950 that the appropriation has reached \$150 million for the original program plus the categorical programs. Total appropriations are divided into the following four categories:

Hill-Burton Original Program \$150 million

last year: \$ 99 million

This appropriation, allotted to the states on the basis of population and per capita income, assists in the financing of new hospitals and related health facilities construction under the original Hill-Burton program. To June 30, 1958, federal funds have partially financed approximately 3,476 projects, including 159,745 hospital beds, 768 public health centers, 23 state health laboratories and something in excess of 100 nurses' homes and training facilities.

Medical Facilities—Category

Program \$35 million

last year: \$21 million

The total allotted to the states this year on a population-per capita-income formula will assist in the financing of new construction under the 1954 amendments in four categories as follows: \$7.5 million for hospitals for the chronically ill and impaired; \$7.5 million for diagnostic centers, or diagnostic and treatment centers; \$10 million

for nursing homes; and \$10 million for rehabilitation facilities. As under the original program, the federal share may range from one-third to two-thirds of the total project cost. As of June 30, 1958, a total of 496 projects had been approved, divided among the four categories as follows: Facilities for chronically ill (93), diagnostic-treatment centers (196), nursing homes (125), and rehabilitation facilities (82).

Hill-Burton Administrative Expenses \$1 million

last year: \$1,450,000

This appropriation is used for administration, including salaries and expenses for the hospital survey and construction program for the federal headquarters and for eight regional federal offices.

Research \$1.2 million

last year: \$1.2 million

Authorized in 1949 but not appropriated until 1955 is this item for research, experiments and demonstrations on utilization of hospital services, facilities and resources. The bulk of the money is assigned as grants to states, universities, hospitals, hospital associations, professional associations, and community organizations and a small amount for direct research by U.S. Public Health Service.

National Institutes of Health \$324,383,000

last year: \$241,183,000

National Cancer Institute \$75,268,000

last year: \$56,402,000

About 50 per cent of this appropriation is earmarked for grants to non-federal individual investigators and private institutions for research and training. Almost 25 per cent will be used to support contracts with the pharmaceutical and chemical industries in research on chemotherapeutic agents for the treatment of cancer. The states receive \$2,250,000 for cancer control work. \$4,212,000 will provide professional and technical assistance to public and private institutions engaged in prevention, diagnosis, and treatment

among individuals and large population groups (cytology activities) and environmental cancer activities. The balance is for direct research operations, including salaries, supplies, and this institute's share in the cost of operating the Bethesda (Md.) clinical center and related auxiliary services.

National Heart Institute\$45,613,000

last year: \$35,936,000

Grants to non-federal individual investigators and public and private institutions for research and training take about 75 per cent of the appropriation. \$2,125,000 is allocated to states for heart disease control. The balance is for direct research operations, including salaries, supplies, and this institute's share in the cost of operating the Bethesda (Md.) clinical center and related auxiliary services.

Mental Health Institute\$52,419,000

last year: \$39,217,000

Approximately 75 per cent of this appropriation is apportioned for research and training through grants to individual investigators and public and private institutions. The sum of \$4 million is allocated to the states for community mental health services. The remainder is for direct research operations, including salaries, supplies, and this institute's share in the cost of operating the Bethesda clinical center and related auxiliary services.

Arthritis & Metabolic Diseases

Institute\$31,215,000

last year: \$20,385,000

Grants to public and private investigators for research and training total 75 per cent of this appropriation. The balance is for direct research operations, including salaries, supplies and this institute's share in the cost of operating the Bethesda clinical center and related auxiliary services.

Neurological Disease & Blindness

Institute\$29,403,000

last year: \$21,387,000

Grants to public and private investigators and institutions for research and training total 80 per cent of this appropriation. The remainder is for direct research operations, including salaries, supplies, and this institute's share in the cost of

operating the Bethesda clinical center and related auxiliary services.

Allergy & Infectious Diseases

Institute\$24,071,000

last year: \$17,400,000

Research grants to public and private investigators for research and training amount to 70 per cent of this appropriation. The remainder is for direct research operations, including salaries, supplies and this institute's share in the cost of operating the Bethesda clinical center and related auxiliary services.

Dental Health Institute\$7,420,000

last year: \$6,430,000

Grants to public and private investigators for research and training total about 60 per cent of this appropriation. Of this, \$983,000 will be used for technical assistance to states and \$320,000 for co-ordination and development of dental resources. The remainder is for direct research at Bethesda, review and approval of grants, administrative expenses, and for support of the clinical center.

National Institutes of Health —

General Funds\$28,974,000

last year: \$14,026,000

These funds are administered by the division of general medical sciences of the National Institutes of Health, with practically all funds being expended for research and training grants, with the exception of \$2,236,000 for control of biologics (including polio and flu vaccine), which activity is under the division of biologics standards. The balance goes toward supporting fellowships and administrative expenses relating to grants.

Laboratory Research Construction

(NIH)\$30 million

last year: \$30 million

There is available for planning and construction of research facilities \$30 million the authority for which is Public Law 835 (84th congress). To be eligible for grants, the applicant must be a public or nonprofit institution determined by the surgeon general, after consultation with the National Advisory Council on health research facilities, to be competent to engage in the type of research for which the facility is to

in corticosteroid
therapy of
allergic diseases
asthma-hay fever
allergic rhinitis
allergic dermatitis
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Excellent and good-to-excellent results are reported[†] with DECADRON in nearly all of 362 patients with various allergic disorders, including a number of cases who had failed to respond to other corticosteroids. No major reactions were observed in these extensive clinical studies even after four months of continuous therapy—DECADRON produced no peptic ulcer, no diabetes, no significant hypertension, no sodium retention, no potassium depletion, no edema, no undesirable psychic reactions, and no unusual or new side effects. Less than five per cent of patients experienced minor reactions, none of which prevented continuing administration of DECADRON.

Moreover, several investigators report that side effects induced by previous corticosteroid therapy such as gastric

intolerance, peripheral edema, headache, vertigo, muscle weakness, ecchymoses, flushing, sweating, moon facies, hypertension, hirsutism, and acne **often disappeared during therapy with DECADRON.**

[†]Analysis of clinical reports.

Dosage: One 0.75 mg. tablet of DECADRON will replace one 4 mg. tablet of methylprednisolone or triamcinolone, one 5 mg. tablet of prednisone or prednisolone, one 20 mg. tablet of hydrocortisone, or one 25 mg. tablet of cortisone.

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be constructed. This is the third year of this program's operation.

Water Pollution Control\$45 million

last year: \$47 million

Under Public Law 660, enacted in 1956, the federal government makes grants for the construction of waste treatment plants. Although \$45 million was appropriated for fiscal 1959, the funds allocated to the states will be based on the \$50 million authorized in the basic legislation.

Hospitals and Medical Care.....\$48,454,000

last year: \$44,399,000

These funds are used for operational costs and maintenance of PHS hospitals and health services in caring for American seamen, coast guard and public health service personnel and their dependents, federal employees injured at work, leprosy patients and narcotic addicts, and includes studies in the development and co-ordination of nursing resources. It also includes \$1 million for payments to Hawaii for care of patients suffering from leprosy and \$5.8 million for nurse training grants. Not shown in the appropriation is approximately \$4.5 million additional income, principally from other federal agencies for reimbursable services.

Indian Health Activities\$44,597,000

last year: \$43,230,300

Under Public Law 568 (83rd congress), PHS assumed responsibility for the health of American Indians and natives of Alaska which formerly was a function of the interior department. The total is broken down as follows: Hospital care in Indian hospitals, \$23,756,000; contract patient care, \$8 million; field health services, \$6,620,000; program direction and management services, \$2,097,000; and modernization of hospitals and construction of facilities \$4,124,000. In addition, the Indian health activities of PHS will receive approximately \$740,000 as reimbursements from other governmental agencies for services rendered in PHS facilities.

Assistance to States—General\$22,889,000

last year: \$22,592,000

Grants totaling \$15 million will be available for allocation to the states in support of state and local general public health activities. These

grants must be matched one state dollar for every two federal dollars. U. S. Public Health Service will spend \$5,889,000 to provide technical assistance, consulting services to states, expenses of the National Office of Vital Statistics, international health activities, demonstrations, training activities, and operational expenses. A total of \$2 million will be available for grants to schools or direct traineeship awards to individuals for the training of professional public health personnel.

Sanitary Engineering Activities\$12,815,000

last year: \$12,640,000

This program is made up of seven activities as follows: Air pollution control, \$3,860,000; water supply and water pollution control, \$6.6 million; radiological health activities, \$608,000; milk and food sanitation activities, \$492,000; interstate carrier and general sanitation activities, \$510,000; sanitary engineering center research activities, \$440,000; and administration, \$305,000.

Tuberculosis Control\$6,386,000

last year: \$7 million

Grants to states for diagnostic and treatment clinics, mass case-finding and follow-up services account for \$4 million, all of which has to be matched equally by the states. The remainder is for direct operations of PHS.

Communicable Disease Activities ..\$8.3 million

last year: \$6,250,000

The entire appropriation is used for direct activities of the PHS communicable disease center at Atlanta, Ga., and its affiliated operations. The center carries on studies in epidemiology, furnishes laboratory diagnostic services and sponsors special projects to assist states. This amount includes \$1.7 million for equipment for the new communicable disease center which is now under construction in Atlanta.

Office of the Surgeon General.....\$5,260,000

last year: \$5.1 million

For administrative expenses of this office, including all housekeeping services, evaluation of public health needs, and personnel training. Included also is approximately \$1,389,400 for administration of the National Health Survey Act authorized by Public Law 652 (84th congress).

Venereal Disease Control\$5.4 million

 last year: \$4,415,000

Of the total, \$2.4 million goes for direct grants to states for venereal disease detection, treatment and control on a special-need basis. Most of the remainder is spent for technical assistance to the states, including funds to pay 258 federal employees, the majority of whom are assigned to state health departments.

Foreign Quarantine Service\$4,108,000

 last year: \$3,876,000

This service operates 310 medical quarantine stations on borders of the United States. It also operates 28 medical examination stations on foreign soil for the examination of aliens seeking visas to enter the U. S. Inspections are made of all seagoing vessels and aircraft entering the U.S. It is estimated that the service will examine more than 3.1 million aliens in this country and 210,000 abroad.

Alaska Health and Sanitation

Programs\$8,665,000

 last year: \$2,165,000

This appropriation will be divided as follows: \$638,00 for grants to Alaska for public health services; \$527,000 for research activities of the Arctic Health Research Center at Anchorage; \$1 million to enable Alaska to pay for hospitalization for Alaska's mentally ill at Morningside Hospital in Portland, Ore.; and \$6.5 million for construction of mental health facilities in Alaska as authorized by the Alaska Mental Health Act.

National Library of Medicine\$8,365,000

 last year: \$1,450,000

As a result of Public Law 941 enacted in 1956, the Armed Forces Medical Library was renamed the National Library of Medicine and transferred to the department of health, education, and welfare. A new structure has been authorized to house the library and \$6,950,000 in construction funds was appropriated for 1959. The new library will be built on the southeast corner of the NIH reservation at Bethesda.

Reimbursable Health Programs for

Other Governmental Agencies\$487,000

 last year: \$475,000

This represents the cost of services expected to be advanced to public health service by other

governmental agencies for establishing and operating on-the-job clinics. PHS deals largely with Washington personnel, whereas 90 per cent of the total number of government's employees are located outside the greater Washington area.

Freedmen's Hospital\$2,975,000

 last year: \$3 million

This institution with an average patient load of 328, plus 32 new-borns, is a medical teaching facility and general hospital. Its patients are chiefly medical indigents from the District of Columbia and the adjoining area. The hospital is utilized for training of interns and residents, chiefly from Howard University, and it has a nurses' training school. A total of \$4,267,000 is authorized for operating cost. All in excess of \$2,975,000 (appropriated for fiscal 1959) are expected reimbursements from charges made to patients and payments made by the District of Columbia and other federal agencies and from the counties surrounding Washington who utilize these facilities for welfare patients. Some supervisory functions over this program is vested in PHS.

Howard University\$1,022,000

 last year: \$1,136,000

This university came into being shortly after the close of the Civil War because of the lack of higher educational facilities for Negroes. It is jointly supported by congressional appropriations and private funds and offers instruction in 10 schools and colleges, including colleges of medicine, dentistry, and pharmacy. This year the university's total operational budget is in excess of \$8 million. Of this amount the federal government will contribute \$4,350,300 toward operational expenses, \$123,000 for plans for construction, and \$163,000 for completion of a men's dormitory. The combined budgets for the colleges of medicine, dentistry and pharmacy will require approximately 24 per cent of the university's total budget. The entire student body of the university for 1958-59 will be approximately 5,500. There are 350 students enrolled in the college of medicine, 289 in the college of dentistry and 133 in the college of pharmacy. The federal contribution for direct current operations in the colleges of medicine, dentistry and pharmacy totals approximately \$1,022,000, according to the university's treasurer.

St. Elizabeth's Hospital\$17,082,000

last year: \$15,904,500

St. Elizabeth's provides treatment for several classes of mentally ill persons, including those residing in the District of Columbia, beneficiaries of the veterans' administration, beneficiaries of public health service, insane persons charged with or convicted of crimes in U. S. courts (including the court of the District of Columbia), certain American citizens found insane in Canada, the Panama Canal Zone and the Virgin Islands, certain foreign service personnel, and members of the military services admitted to the hospital prior to July 16, 1946. Congress appropriated \$3,186,000 to this institution for operational expenses, \$87,000 for major repairs, and \$125,000 for construction planning. Reimbursements from other agencies will approximate \$13,684,000. This hospital has an average daily patient load of 7,000.

Bureau of Public Assistance

(Medical Payments)\$240 million

last year: \$150 million

Out of a total budget of approximately \$3.2 billion (federal and state) for categorical public assistance programs, officials of the social security administration estimate that approximately 12.8 per cent is now being devoted to health care of recipients. For all facets of living expenses and medical care, the total federal contribution this year will be about \$1.9 billion. An estimated \$410 million of federal, state, and local funds are expected to be paid for medical and health needs of categorical assistance recipients this fiscal year. About \$330 million will be paid to vendors of medical care, such as physicians, hospitals, pharmacists, nursing homes, etc., and about \$80 million directly to recipients to enable them to meet their medical care needs. The federal share of combined medical payments to vendors and to recipients will be about \$240 million.

Office of Vocational Rehabilitation . \$57.8 million

last year: \$50,830,000

Under the expanded Vocational Rehabilitation Act (Public Law 565, 83rd congress), congress this year appropriated \$56.4 million for grants to states and other agencies. This is divided as follows: (a) Support of basic rehabilitation services, including medical examinations, surgical

and therapeutic treatment, hospitalization, prostheses, occupational tools and aids, vending stands, rehabilitation facilities, vocational training and funds for maintenance (based on per capita income and population as in Hill-Burton), \$45.5 million; (b) Extension and improvement of state programs, \$1.5 million; (c) Special grants to states or nonprofit organizations for projects designed to expand the rehabilitation program (2-1 federal-state matching), \$4.6 million; (d) \$4.8 million for training of rehabilitation personnel, including physicians, therapists, psychologists, counselors, medical and psychiatric social workers. In addition \$1.4 million is available for federal administrative costs.

Children's Bureau\$32.3 million

last year: \$32.3 million

Operating under the social security administration, the children's bureau administers grants to states for maternal and child health, and child health, and crippled children's and child welfare services. This year grant money totals \$43.5 million divided as follows: \$16.5 million for maternal and child health work; \$15 million for crippled children's services; and \$12 million for child welfare services. However, this last item has no medical significance and, therefore, it is not reflected in the total of \$32.3 million. One-half of the federal funds for maternal and child health and crippled children's services is required to be matched dollar for dollar by the states. In addition, the children's bureau has \$2 million to finance investigating and reporting activities and to administer all the grants. About 40 per cent of this amount is chargeable to the health and related activities of the children's bureau which include administration of grants for maternal and child health and crippled children's services and consultative services to state agencies and other public and voluntary agencies and organizations engaged in the provision of maternal and child health services.

Federal Surplus Property

Donation Program Approx. \$18,319,806

last year: \$15.2 million

The department of HEW has authority to make donations of personal property and transfer of real estate declared surplus by federal agencies for health needs. In the case of real estate, conditional title is vested in the transferee and then after a number of years of utilization

of the property in accordance with imposed conditions the property can become absolutely vested. Recipients of personal property may be medical institutions, health centers, hospitals and clinics. Eligible donees of real property may be any institutions organized for health purposes, including those engaging in medical research. It is difficult to determine the exact value of property donated and transferred since accounting is on the basis of acquisition cost. Last year approximately \$60,910,000 of personal property (acquisition value) was allocated for health purposes which probably had a fair market value of roughly \$18 million. During the same period, approximately \$1,229,582 of real estate (acquisition value) was transferred with a fair market value of \$319,806. It is expected that the level of donations and transfers for the current fiscal year will be in line or slightly in excess of last year's totals.

*Contract Hospitalization**\$13,557,000

last year: \$13,389,000

This appropriation finances an average daily patient load of 3,117 veterans in federal hospitals other than VA and in state and municipal hospitals. Patients in federal non-VA hospitals are estimated at 1,324 and in non-federal hospitals, 1,676. Mental cases make up the largest single category of contract cases.

*Medical Administration**\$7,175,000

last year: \$7,862,000

To operate the VA department of medicine and surgery in the central office and the seven area medical offices; included are salaries, travel and like expenses.

Medical Research\$16,344,000

DEPARTMENT OF DEFENSE

(This Year: Approx. \$751,115,000 —

Last Year: Approx. \$702,305,000)

*Army Medical Services** ..Approx. \$295 million

last year: \$270.7 million

The estimated cost includes expenses normally associated with the operation of military hospitals and dispensaries, military and civilian salaries, medical supplies and equipment, utilities, communications, transportation travel subsistence, maintenance and repair of buildings and grounds, expenses for construction, dependent

last year: \$11,344,000

For research, mostly in VA hospitals. The breakdown: general medical and surgical research, \$9,600,700; atomic medical research, \$2,803,300; prosthetics testing, \$1 million; neuropsychiatric, \$1,659,100; tuberculosis, \$1,130,900; other, \$150,000.

Alterations, Improvements and

*Repairs**\$2.7 million

last year: \$2,028,000

For alterations, improvements and repairs to VA clinics and domiciliaries (costing less than \$300,000 per project).

*Supply Depot Operations**\$2,055,000

last year: \$1,790,000

For maintaining and operating supply depots handling the purchase, shipping and storage of medical supplies and equipment used by the department of medicine and surgery.

*Medical Education and Training** ...\$1,339,000

last year: \$1.4 million

For VA training programs for physicians and other VA personnel in medical specialties and auxiliary services.

Medical Care—Philippine Veterans ..\$1,250,000

last year: \$1.5 million

Until 1960 the U. S. will contribute for the medical care of Philippine veterans.

*In appropriating for VA, congress stipulated that the funds were predicated on furnishing care and treatment for 140,490 beneficiaries during this year. This total of beneficiaries was arrived at by adding the estimated number of veterans to be cared for in VA hospitals, domiciliary facilities, contract hospitals, and state veterans homes. There is no way of estimating whether more or fewer patients than this total will be cared for during the year. If VA doesn't furnish care at this level, its funds will be reduced proportionately.

medical care, medical education and training, medical research and preventive medicine.

*Naval Medical Services** ..Approx. \$235 million

*A defense department source gives this explanation: All dollar amounts are estimates and have been rounded because military appropriations are not broken down into categories of medical expenditures. The estimated increase during fiscal year 1959 in the total military medical programs (about \$49 million higher than was estimated in October of 1957 for the fiscal year (1958) is primarily attributable to an increase in the cost of goods and services and because of an increase in salaries for military and civilian personnel, approved in the latter part of fiscal year 1958. It is estimated that the average daily patient load will approximate the same as for fiscal 1958 and that in the combined military services in-patient hospital care this year will cost about \$319 million. Out-patient care, which will cost about \$171 million because of an estimated 34 million out-patient visits, excluding dental visits, reflects a small reduction in workload due to reduction in military population.

The 85th congress placed restrictions on the dependents medical care program (Medicare). Because of these changes, reliable program cost estimates cannot be made at this time.

last year: \$220.1 million

The estimated cost includes expenses normally associated with the operation of military hospitals and dispensaries, military and civilian salaries, medical supplies and equipment, utilities, communications, transportation travel subsistence, maintenance and repair of buildings and grounds, expenses for construction, dependent medical care, medical education and training, medical research and preventive medicine.

Office, Asst. Secretary of Defense

(Health & Medical) Approx. \$115,000

last year: \$105,000

For salaries, travel and administration of this office, and for travel expenses and consultant fees for the defense department civilian health and medical advisory council.

ATOMIC ENERGY COMMISSION

(This Year: \$45,462,000 —

Last Year: \$40,085,000)

The Atomic Energy Commission's division of biology and medicine has about \$5.4 million more than last year for research projects. This year's total includes the following spending plans: Cancer, \$4,172,000; other medical, \$12,268,000; biological, \$14,104,000; biophysical, \$1,784,000; development of new laboratory equipment, \$2,498,000; vocational and special training, \$2,220,000; radioisotope distribution, \$310,000; environmental science, \$5,394,000; and miscellaneous items, \$2,712,000.

INTERNATIONAL CO-OPERATION

ADMINISTRATION

(This Year: \$39,600 —

Last Year: \$37,300,000)

Technical Co-operation Health

Programs

\$14 million

last year: \$14 million

The international co-operation administration through co-operatively financed programs is helping 44 countries, at their request, to improve their health and living conditions. The broad range of health projects falls into the fields of: (1) Epidemic and infectious diseases (malaria, trachoma, small pox, typhoid); (2) Environmental sanitation (safe water systems and sewage disposal); (3) Development of rural health services and facilities (health centers, hospitals, clinics, laboratories); (4) Training of personnel both locally and in the United States;

(5) The establishment and development of basic health training institutions (schools of nursing, schools of public health).

Malaria Eradication Program\$25 million

last year: \$23 million

In the Mutual Security Act, the 85th congress authorized U. S. participation in a world-wide malaria eradication program not to exceed the amount indicated above.

DEPARTMENT OF STATE

(This Year: \$21,638,380 —

Last Year: \$15,718,110)

United Nations Children's Fund\$11 million

last year: \$10 million

The United State's share of the children's fund is up about \$1 million over last year for a total of \$11 million. The percentage of U. S. contribution to the total fund has dropped slightly from 55 per cent to 52.5 per cent. Other governments increased contributions from \$8.2 million last year to \$9.9 million this year. There are 81 contributing governments and territories. The fund is aiding 324 health and medical projects in 104 territories and benefiting 50 million children and others. More than 45 million children and pregnant and nursing mothers benefited directly from the fund last year. More than 14 million children were vaccinated against tuberculosis, some 28 million were protected with DDT against malaria, some 2.8 million children and mothers were treated for yaws, bejel, or syphilis, 900,000 children were treated for trachoma.

World Health Organization\$7,424,380

last year: \$4,200,110

This country's share of the WHO budget remains at about one-third of the total assessments of the 85 member governments. Last year WHO was sponsoring about 600 projects in 117 countries and territories. WHO's overall budget is broken down this way: Approximately 88 per cent for operating programs, 9 per cent for administration, and the rest for organizational meetings. WHO actually had three appropriations from the U. S. The first is for \$4,666,480 for its general activities; the second for \$300,000 for research; and the third for \$5 million for malaria eradication which will come from ICA's \$25.6 million. This organization also administers \$5,462,000 obtained from the U. N. technical

assistance program. Approximately \$2,457,900 of this total comes from the U. S.

Pan American Sanitary Bureau\$1,914,000

last year: \$1,518,000

The United States is contributing approximately two-thirds of the bureau's regular budget which this calendar year totals \$3 million. In addition, this country hopes to allocate \$3 million for 1959 malaria eradication programs which will come from ICA's \$25.6 million. The bureau, in existence many years before WHO was organized, is the regional office of WHO for the Americas. The bureau is sponsoring health programs in 20 Latin American countries, dependent territories of European powers in this hemisphere, and the United States.

Health Program for Overseas

Employees\$1.3 million

(new program)

The department of state furnishes health care to 10,000 overseas employees and approximately 15,000 of their dependents. In the case of dependents, the government pays for medical care after the first \$35 of expense incurred for a single illness. In most cases, military medical facilities of our government overseas and facilities operated by the United States Public Health Service are utilized. However, in some cases private physicians and private hospitals are used.

NATIONAL SCIENCE FOUNDATION

(This Year: \$19,575,000

Last Year: \$7.5 million)

The foundation's overall budget of \$130 million is \$90 million above last year's appropriation. The sum of \$19,575,000 is earmarked for research grants in the biological and medical sciences. The foundation provides support for basic scientific research, for training and education in the sciences through fellowships and programs to improve science teaching, and programs to improve exchange of scientific information.

OFFICE OF CIVIL AND DEFENSE

MOBILIZATION

(This Year: \$13,617,000

Last Year: \$3,177,000)

Under Reorganization Plan No. 1 of 1958, the federal civil defense administration and the office of defense mobilization were consolidated into what is now the Office of Civil and Defense

Mobilization. The total budget for this new agency is \$45,285,000. The health and medical activities will expend \$13,617,000 broken down as follows: Salaries and expenses \$403,000; research \$179,000; education (medical education for national defense), \$135,000; federal medical stockpiling \$12.4 million; federal matching contributions re medical equipment for state agencies, \$500,000.

FEDERAL EMPLOYEES' HEALTH PROGRAMS

(This Year: \$11 million —

Last Year: \$10 million)

Another health program, this one available to all federal civilian workers, provides limited services through health clinics. They are operated by federal agencies which employ 300 or more persons in any one area. By regulation, maximum cost of a health service cannot exceed \$13 a year per employee, although special industrial conditions or minimal size units may warrant a higher ceiling. Services include treatment for on-the-job illness and physical examinations for employment.

DEPARTMENT OF LABOR

(This Year: \$8,827,000 —

Last Year: \$8,069,476)

Bureau of Employees' Compensation . \$8.2 million

last year: \$7.5 million

An estimated 3,447,000 federal workers are eligible under the Federal Employees' Compensation Act for medical and hospital care, rehabilitation services, disability and death payments, funeral and burial expenses. For treatment of employees by private doctors and hospitalization in private facilities, the labor department has set aside \$6.2 million this fiscal year, and for similar services in federal hospitals and clinics, \$2 million. Expenditures for care by non-governmental physicians and in private hospitals has been increased by \$545,000 over last year's spending level.

Bureau of Labor Standards\$627,000

last year: \$569,476

For promotion of industrial safety, the bureau plans to spend \$412,300, and for re-employment programs of the physically handicapped, \$214,700. The agency develops standards for hazardous occupations, assists the states in accident prevention programs and assists states and unions in training safety personnel.

PANAMA CANAL COMPANY AND PANAMA CANAL ZONE GOVERNMENT

(This Year: \$3,959,900)

Last Year: \$5,988,300)

Expenditures for fiscal 1959 for operation of Canal Zone hospitals and clinics is estimated at \$6,343,800. Medical services are available to Zone employes and their dependents, certain military and other persons. Some of these patients make payments toward the cost of their medical care, which payments are returned to the United States Treasury. In 1959 such revenue is estimated at \$3,266,200. When last year's report was compiled, the revenue figure was not obtainable. Expenditures for operating public health activities, including sanitation, health director's office, division of veterinary medicine, preventive medicine and quarantine and general government expense applicable to the health bureau, should total \$882,300. The four hospitals operated by the health bureau of the Canal Zone government contain 1,008 beds as follows: Gorgas Hospital (440), Coco Solo Hospital (148), Corozal (300), Palo Seco Leprosarium (120). In addition there are two dental clinics, one medical clinic and five first-aid stations.

DEPARTMENT OF TREASURY

(This Year: \$3,854,500)

Last Year: \$3,837,850)

The bureau of narcotics, operating within the treasury department, is primarily engaged in investigation, detection and prevention of violations of the federal narcotic and marihuana laws. Subsidiary functions are : (1) Exercising control over the legitimate manufacture and distribution of narcotics within the United States through a quota-system and supervision over approximately 302,000 qualified registrants (physicians, pharmacists, dentists, wholesalers, etc.); and (2) Training of narcotics law enforcement officers sponsored by local and state law enforcement agencies. Increased emphasis is being placed on drying up interstate and international sources of illicit supplies.

DEPARTMENT OF JUSTICE

(This Year: \$2,105,000)

Last Year: \$,796,000)

The figure represents the bureau of prisons' estimate of the cost of medical and dental services for approximately 22,000 prisoners in 30 federal penal institutions. The bulk (about \$2 million) goes to commissioned officers of the public health service assigned to the prisons

and to related civil service personnel for services that include psychiatric, medical, surgical, nursing and dental treatment. Another approximately \$105,000 is earmarked for fees to 220 consultants in various medical specialties.

DISTRICT OF COLUMBIA

(This Year: \$2 million)

Last Year: \$3.7 million)

Only a rough estimation can be made of the federal contribution for health and medical programs of the District of Columbia. The total District budget for all governmental functions is in the neighborhood of \$204 million. Congress has appropriated \$20 million for this year toward the cost of the District government or about one-tenth of the total. The District health department will expend \$32,605,000. In this amount is included approximately \$122,498,000 for care of the District's insane in St. Elizabeth's Hospital. Since such sum is shown in this report under St. Elizabeth's Hospital, it may be deducted from the District's appropriation for public health, leaving a net balance of \$20,107,000 in that category. Since the federal contribution to the District budget represents only one-tenth, then the federal contribution attributable to health and medical activities can be approximated at \$2 million.

FEDERAL TRADE COMMISSION

(This Year: \$1.6 million)

Last Year: \$1 million)

The commission plans to spend about the same as last year for research, testing and compliance operations in the field of food, drugs, cosmetics and devices. This is nearly 20 per cent of the agency's total budget of \$5,975,000. FTC is charged by congress with the safeguarding of life and health of the public through the prevention of the dissemination of false advertisements of various products.

DEPARTMENT OF COMMERCE

(This Year: \$1,212,400)

Last Year: 911,300)

Civil Aeronautics Administration \$600,000

last year: \$385,000

Spending for the Civil Aeronautics Administration flight safety program is divided as follows: \$375,000 for salaries and administrative expenses at headquarters; \$170,000 for similar expenses in regional offices; \$55,000 for the CAA Medical Research Laboratory at Oklahoma City. Five full-time and four part-time medical

officers in the field supervise the periodic physical examinations required of commercial and private pilots. CAA has 1,826 designated medical examiners in the United States and overseas. A total of 225,614 examinations were made last year and a similar number are expected to be made this year. For this service, pilots pay examining physicians directly.

National Bureau of Standards\$612,400

last year: \$526,300

The bureau of standards performs tests and engages in developmental research on its own initiative and at the request of others. The bureau will expand \$176,800 of its own money this year as follows: \$117,200 for radiation research; \$43,000 for audiometric calibrations research; \$16,600 for dental materials research. In addition the bureau will receive \$435,600 from other agencies, divided as follows: \$71,100 for radiation research; \$91,000 for air pollution research; \$49,000 for instrument testing; \$63,500 for anesthesiological and respiratory equipment evaluation; \$93,000 for dental materials research; and \$68,000 for preparation of C-14 labeled carbohydrates.

CIVIL SERVICE COMMISSION

(This Year: \$426,000

Last Year: \$387,000)

The commission's total budget is approximately \$18 million, out of which about 2.3 per cent goes to the medical division for salaries of eight physicians in Washington and 11 in the regional offices. The medical division's duties include establishing and reviewing physical standards for all civilian jobs in the federal government, supervising and adjudicating disability claims for retirement, and setting professional standards of doctors and ancillary personnel to be employed in government in the competitive civil service.

PRESIDENT'S COMMITTEE FOR EMPLOYMENT OF PHYSICALLY HANDICAPPED

(This Year: 214,700 -

Last Year: \$182,575)

Projected spending is for salaries and administration in the development and promotion of educational programs among employers and the general public to stimulate employment of qualified physically handicapped persons. It also entails expenses in connection with the National

Employ the Physically Handicapped Week.

SMALL BUSINESS ADMINISTRATION

(This Year: \$150,000 -

Last Year: \$70,000)

The small business administration provides financial assistance to hospitals, convalescent and nursing homes, medical and dental laboratories, and physicians for expenses, improvements and general operations. Small business administration loans are of two types: participation loans, those made jointly with banks and other private lending institutions; and direct loans, where no participation is available. Since all loans must be of such sound value or so secured as reasonably to assure repayments, no program losses are anticipated. SBA officials estimate that administrative expenses for the headquarters and field offices will approximate \$150,000, which is about 1.5 per cent of the total administrative fund available for all lending operations.

DEPARTMENT OF THE INTERIOR

(This Year: \$140,000

Last Year: \$154,950)

The bureau of mines, operating within the department of the interior, has a total appropriation of \$5,585,000 for health and safety activities for this fiscal year. Identifiable health programs and expenditures are as follows: \$41,000 for a program for silicosis prevention in mines; and \$99,000 for studies on natural and equipment fuel gases in mines and effect of radioactivity in metal mines.

NATIONAL ADVISORY COMMITTEE TO SELECTIVE SERVICE

(This Year: \$19,000

Last Year: \$19,000)

In requesting this budget, which is the same as last year's appropriation, the national advisory committee to selective service was informed by the military it probably would not be necessary to make draft calls for physicians in the current fiscal year. In any event, if calls were necessary, they would be less than the level which obtained when state and territorial offices and staffs were in operation. Congress provided the \$19,000 appropriation for a skeleton staff and for state committees which are now on a stand-by basis. Because it now appears that several hundred physicians will have to be called before next June 30 via the draft, additional funds will be requested. The national advisory committee has the responsibility of advising selective service on deferment policies

for physicians in residencies, teaching positions, essential laboratory and clinical research and persons deemed necessary to protect civilian health at a time when draft calls are being made. The state and territorial committees assist the national committee when their services are required.

**OFFICE OF THE ATTENDING
PHYSICIAN OF CONGRESS**

(This Year: \$13,145)

(Last Year: \$12,145)

Since 1928, the office of the attending physician of congress has provided out-patient care for members of the house and senate and their staffs. By an act of that year, the office has been filled by a medical officer of the United States Navy. Sole occupant of the post has been Rear Adm. George W. Calver (MC), USN. Funds voted by congress are for medical supplies and equipment and contingent expenses. Salaries of Dr. Calver, his assisting physicians and enlisted corpsmen are paid from navy funds.

**PAYMENTS TO INDIVIDUALS BECAUSE OF DISABILITY THROUGH PROGRAMS
IN WHICH THE U. S. GOVERNMENT PARTICIPATES**

(fiscal year ending June 30, 1959)

(Small groups of federal retirees' plans not listed; administrative cost of program omitted)

Program	Estimated Beneficiaries	Approximate Payments
Veterans' benefits		
A. Service-connected disability	2,445,000a	\$2,013,000,000a
B. Non-service-connected disabilities	1,332,000b	1,135,000,000b
Military retirement permanent & temporary disability	82,600	221,840,000
Federal employes compensation (payments)	136,500	24,835,000
(These programs fully financed by U. S.)		
Public assistance		
A. Aid to needy permanently & totally disabled	336,000	260,200,000c
B. Dependent children aid (incapacitated father segment)	722,000d	235,000,000d
C. Aid to the blind	108,800	90,400,000e
Disability Annuity Payments to Civil Service Retirees	90,000f	127,000,000
(Public assistance financed 55 per cent U. S. and 45 per cent states; Civil service financed 50 per cent U. S. and 50 per cent employes.)		
Social security — OASI disability		
A. Disability over age 50	262,000g	333,000,000
B. Childhood disability benefits (h)	52,000h	24,000,000
C. Dependents of disabled workers (i)	80,000i	50,000,000
(These Programs financed by OASI Payroll Tax)		
Railroad retirement disability		
A. Permanent disability for regular job	30,000	42,000,000
B. Permanent disability for all employment	71,000	88,000,000
C. Temporary disability	150,000	50,000,000
(These programs financed 50 per cent employers-50 per cent employes.)		\$4,694,275,000
Total	5,897,900j	

a 388,000 dependents in this total; program decreasing as beneficiaries die.

b 511,000 dependents in this total; program is increasing rapidly.

c \$143.9 million of this total is provided from U. S. funds. Additional program administrative cost is about \$29.8 million (11.5 per cent); U. S. share is \$14.9 million.

d Provided to 167,000 families. \$142.8 million of benefits is federal. Additional administrative cost is \$22.8 million (9.7 per cent); U. S. share is \$11.4 million.

e U. S. contribution to program is \$45.4 million. Additional administrative cost is \$6.6 million (7.3 per cent); U. S. share is \$3.3 million.

f Number of persons in this program increased by 11,400 over last year.

g 262,000 beneficiaries are estimated at mid-year; by July 1, 1959 estimate is 330,000.

h Eligibility based on disability incurred before age 18; the 52,000 beneficiaries listed is at mid-year; by July 1, 1959 total will reach 73,000.

i Does not include any childhood disability beneficiaries entitled to benefits as dependents of disabled workers; the 80,000 beneficiaries listed is at mid-year; by July 1, 1959 total will reach 134,000.

j No adjustment made for payments to one individual through more than one program.

C.C. Flemming Cites AMA Joint Effort Against Food Faddism and Quackery.

HEW Secretary Flemming reports a "disturbing increase" in quackery involving false and misleading claims for a variety of vitamins, minerals and other food supplements. Operations in this field have become the most widespread and costly form of medical quackery in the country today, he told a press conference. He quoted an American Medical Association estimate that such operations are costing 10 million Americans over \$500 million a year.

The secretary reported that the food and drug administration had 350 inspectors, but that they were not enough. "In fighting quackery, law enforcement, of course, is only part of the answer. It is perhaps even more important to help the public understand the facts about nutrition and to warn people against false claims and theories," he commented. "In this connection I cannot commend too highly the educational program against food faddism and quackery being sponsored by the AMA, the National Better Business Bureau and the FDA." In October, AMA distributed a comprehensive campaign kit to secretaries and executive secretaries of state and county medical societies to help them organize local drives against food faddism, which AMA noted was spreading throughout the country with "alarming speed."

D.D. Medicare Costs Mounting, Now Running at \$9.2 Million Monthly.

The medicare program is increasing in cost, according to Brig. Gen. Floyd L. Wergeland, head of the office for dependents medical care. For October, costs rose to \$9.2 million, the highest since the operation began nearly two years ago. It was also the first month of restricted benefits, although the October total includes payments for services rendered some time back. If the present rate of costs continues, it would appear obvious that the \$72 million voted by the last congress for the civilian phase of the program will be used some months before the end of the fiscal year. For instance, were the October rate to continue for the rest of the fiscal year, the total would amount to around \$106 million. Defense department could ask for a deficiency appropriation.

E.E. Action on Air Pollution Control Promised.

One of the problems congress will wrestle

with is the extension and possible expansion of the Air Pollution Control Act, now in its fourth year. Its author, Senator Kuchel (R., Calif.) told the three-day national air pollution conference called by the public health service, that he would seek enactment of a bill extending the act beyond 1960. He did not go into details of expansion, although he pointed out that congress had voted only \$12 million of the \$25 million authorized over a five-year period for research and investigation projects into air pollution.

Surgeon General Burney of the public health service told the conference that controlling air pollution will cost "big money but it is an essential investment."

A number of speakers developed the theory that there were definite links between cancer and air pollution. Dr. Burney reported that cancer can be produced in animals using concentrates of urban smog, and that lung cancer deaths in the larger cities are twice those in non-urban areas. "The case has not yet been proved, but the weight of circumstantial evidence grows heavier as research progresses."

Automobile exhausts and nuclear weapon testing were cited by others as sources of potentially dangerous pollution. Dr. Herman Hilleboe, commissioner of health for New York State, urged a crash program of recruitment and training by PHS similar to those for venereal disease and tuberculosis launched in 1936 and 1944. Primary emphasis at that time was on loaning personnel to help states and communities set up effective disease control programs.

F.F. Social Security Staff Being Increased.

The 1958 amendments to the social security law have so increased the workload of the bureau of old age and survivors insurance it has added about 1,600 civil service employees and expects to add another 1,300 later. This was disclosed by HEW Secretary Flemming who said he was pleased at the prompt and effective way in which the social security administration has worked to put into effect the new benefits provided in the amendments. An estimated 12.3 million persons now are receiving OASI benefits.

G.G. Infant Death Rate Shows Increase First Time in 22 Years.

The infant death rate in the United States is on the increase. The increase is slight, but it is the first time in 22 years that the percentage of deaths has not shown a decline. The trend,

based on children's bureau statistics, was disclosed by Undersecretary Bertha S. Adkins of the department of health, education, and welfare at a convocation of the Children's Aid and Adoption Society of Orange, N. J. Her text was released in Washington.

Preliminary estimates for 1957, Miss Adkins said, showed an increase in infant mortality rate from the 26 per 1,000 live births in 1956 to 26.3. Deaths within the first month also showed a slight increase, from 18.9 per 1,000 in 1956 to 19 in 1957. For the first eight months of 1958, the rate continued its rise, to 19.5.

This break in our progress in conserving infant life," she said, "means an estimated loss of more than 4,000 babies in 1957 and the first eight months of this year."

The downtrend of mortality was reversed in spite of a doubling since 1945 of the percentage of infants served by well-child conferences. In explanation of the situation Miss Adkins said:

"Because of the large number of families that seek such services for their babies, it sometimes has been necessary to sacrifice quality of care somewhat. Many health departments are distressed that overcrowding of clinics makes it impossible for physicians to give adequate time and attention to the mothers and children who need medical guidance and care.

"These service problems are now generally more acute in the cities, because of the changing nature of city populations. In recognition of this, our social security law was amended to make grants-in-aid funds more generally available to city children. Previously, these grants had been predominantly available only to children in rural areas. Another development — the earlier discharge of mothers and infants from large municipal hospitals — emphasizes the need for more comprehensive supplementary community services, including services to mothers and their infants in their own homes."

H.H. NIH Studies Impact of U. S. Grants on Medical Schools.

To learn how research grants from the federal government affected medical schools as a whole, the National Institutes of Health is making a survey of 20 representative institutions. Announcement of the study was made by HEW Secretary Flemming in a talk to the Association of Land Grant Colleges, in which he also warned against the danger of federal influence on edu-

cation if U. S. grants make up too large a part of the schools' budgets. To learn the impact of grants on the schools, a team of top-flight staff people from NIH is visiting the institutions and sitting down with officials in charge for round-table discussions. Mr. Flemming urged the schools themselves to study how grants are affecting them preparatory to the visit of the U. S. officials. The secretary commented:

"The federal government and our institutions of higher education have entered into a far-flung and tremendously significant partnership. I think it is significant that the President and congress have said that the time has come to evaluate this partnership — not from the standpoint of its impact on the federal government, but from the standpoint of its impact on institutions of higher education."

I.I. National Health Survey Makes First Major Report on U. S. Illness.

The national health survey has made its first report on illnesses, injuries and physician visits based on a full year of nationwide household interviews covering 36,000 homes and 115,000 persons. The survey is a continuing program authorized by the 84th congress. On the 50-page study released by public health service, Surgeon General Burney comments: "With this first annual summary, the health survey is beginning to produce a comprehensive picture that workers in the health field have long needed." Some of its findings based on the sample for the period July 1957 to June 1958:

Disability — Civilians not in institutions experienced 3,370 million days of restricted activity due to illness or injury, or 20 days of restricted activity per person per year. During the same period, there were about 1,310 million days of bed disability due to illness or injury which amounted to an average of 7.8 bed-disability days per person a year. (Bed-disability days are days in which a person spent all or most of the day in bed because of illness or injury. A day spent in a hospital is considered to be a bed-disability day.)

Acute conditions — Approximately 438 million cases of acute conditions of all types had their onset during the year, with 284 million respiratory conditions such as colds, pneumonia and influenza. The Asian flu epidemic was cited as an important factor in the high incidence. There was a slightly higher incidence of acute

conditions among females than males, and the incidence decreased with age. Injuries ranked second among acute conditions as reason for time lost from work.

Chronic conditions — while cases of chronic conditions had not been completed, the survey noted that circulatory conditions resulted in 484 million days of restricted activity, 167 million days of bed disability and 68 million days of work loss. Digestive conditions and arthritis and rheumatism conditions ranked second and third.

Physicians visits — There were an estimated 890 million physician visits, about two-thirds of them in offices. Visits were higher in the October-December period than any other quarter. Females used physician services at a greater rate than males (6.0 visits per person for women compared with 4.5 visits per men.) About 75 per cent of visits involved diagnosis and treatment as against services of a preventive nature such as checkups and immunization. Note: The survey estimated visits averaged about 4,000 per doctor, but this was based on the assumption there are roughly 220,000 practicing physicians in the U. S.

J.J. AFL-CIO Urges Nationwide Blood Bank Plan.

The AFL-CIO is urging that a nationwide, uniform, voluntary blood bank system be set up under auspices of the joint blood council. The proposed system would include uniform mandatory licensing standards and a national clearing house or exchange for blood and blood credits. The joint blood council is made up of the American Medical Association, the American Hospital Association, the American Society of Clinical Pathologists, the American National Red Cross, and the American Association of Blood Banks.

K.K. Consultants Group on Medical Education Announced by Burney.

A 21-man consultant group on medical education has been activated by Surgeon General Burney for the purpose of getting answers to this question: "How can the nation be supplied with adequate numbers of well-qualified physicians over the next decade?" Seventeen members have been announced; four others will be named shortly. The group held its first meeting Dec. 8.

Chairman of the group is Frank Bane, former executive secretary of the council of state gov-

ernments and active in public affairs for more than 30 years. Other members include Dr. Edward L. Turner, American Medical Association's council on medical education and hospitals; Dr. Ward Darley, Association of American Medical Colleges; Dr. Julian Price, AMA trustee; Dr. Edwin L. Crosby, American Hospital Association; Dr. Vernon Lippard, Yale medical school dean; John McK. Mitchell, Pennsylvania medical school dean; Dr. Isador S. Ravdin, Pennsylvania medical affairs vice president; Dr. Clayton G. Loosli, Southern California medical school dean; Dr. Charles E. Smith, University of California public health school dean; Morris Thompson, president, Kirksville College of Osteopathy and Surgery; Harold Hillenbrand, DDS, American Dental Association; Miss Marion Sheahan, National League for Nursing; Dr. Harold L. Enarson, Western Interstate Commission for Higher Education; Emory Morris, DDS, president, Kellogg Foundation; Douglas E. H. Williams, Dunbar Community Association; Fred C. Cole, Ph.D., Tulane.

Dr. Burney in his letter of invitation to the consultants said that whether there is an absolute or relative shortage of physicians, the need for doctors will increase in the immediate future.

L.L. Flemming Sees Medical Care for Aged As Basic Issue.

HEW Secretary Flemming says the proposal for hospitalization and surgical services for social security beneficiaries is a basic issue facing the country today. He told another of his "listening" conferences that HEW had no position on the proposal by Rep. Aime Forand (D., R.I.) but that "unquestionably we will have to develop" a position looking to testimony before the house ways and means committee. The conference was on social security, public assistance and child welfare.

He noted that the committee had set a Feb. 1 deadline for submission of a HEW report on the various means for providing medical care for the retired aged, including use of social security. Because of his desire to consult with as many different groups as possible on the subject, Mr. Flemming indicated he may ask for an extension of a week or two on the Feb. 1 deadline.

The conference developed these other points: (1) Need for HEW to confer with internal revenue service to see that a more uniform stand

is taken on arrival at tax-exempt status of many private groups working in the health and welfare fields, (2) The possibility of the U. S. providing a fifth category of public assistance known as general assistance, with provision of medical care as a starter and (3) Need for lowering disability payments below age 50.

M.M. FDA Lists 118 Additives Exempt Under New Control Law.

Acting to initiate the new food additives control law, the food and drug administration has prepared proposed regulations and compiled a list of 118 food additive chemicals that it believes should be exempt from testing. Regulations and list will be published in the Federal Register, making it possible for qualified authorities to review the chemicals and decide whether more tests should be made.

FDA explains that the list should not be regarded as "complete," as it is expected additions will be made to it from time to time as authorities come to agreement on other additives that don't require pre-testing. Unless food additives show up on this or subsequent lists, they must be pre-tested and the results turned over to FDA, which then decides whether the substances may be added to food, and if so under what conditions and in what quantity. Complete details of the proposed regulations and list will be made public shortly when they appear in the Federal Register.

N.N. Grants Total More Than \$4.5 Million.

Recently-announced medical grants and fellowships awarded by the National Institutes of Health and Atomic Energy Commission total more than \$4.5 million. NIH reported that during October it allocated \$603,344 for 157 fellowships and \$3.6 million for 366 research projects. Highest institute total was \$912,156, from the heart institute for 47 research projects. All but \$641,615 of the research money went for continuation of projects approved previously. AEC has awarded \$326,510 to colleges and universities, including 11 medical and public health schools, to help expand facilities for training in radiation biology and the use of radioisotopes. Largest grant (\$25,000) went to the University of Minnesota School of Public Health. Minnesota's medical school also received a separate grant of \$9,000.

O.O. Chairman Mills Sees Neither Tax Cut Nor Wide-Open Spending.

Chairman Wilbur Mills (D., Ark.) of the key

house ways and means committee, outlining his expectations for the coming session, says he expects no tax cut, but at the same time he believes the overwhelmingly Democratic congress will not be in a wide-open spending mood. All taxation proposals, including such social security measures as the Forand bill, are handled by this committee.

Mr. Mills's remarks were made to New York meetings of the Association of Mutual Savings Banks and the Tax Foundation, and released in Washington by the ways and means committee. He said it was a "hard, cold fact" that federal spending has been increasing in an "inexorable" way since the country was founded, from \$4 million for two years to an anticipated \$80 billion the current fiscal year. He did hold out some hope for revision of the progressive rates in the income tax brackets to encourage investment, and a broader tax base. He commented:

"... We are faced with the likelihood that people will continue demanding more and more services from the government. Therefore, as much as I would like to believe that this growth in our economy, and the resulting increase in our revenue level, will dissolve this fiscal shortage we face, I do not feel justified in relying on this alone. As a result, I have been forced to conclude that it is not enough to say that we can iron out the many problems in our tax structures as soon as tax reductions become possible, because, in all frankness, I am not at all certain when that day is coming."

P.P. Auto Exhaust Studies Planned at PHS Sanitary Engineering Center.

Public health service is moving ahead on research projects in air pollution, which was the subject of extensive examination at the recent national conference on air pollution. Work is centering at the Robert A. Taft Sanitary Engineering Center in Cincinnati. Two irrigation chambers are being constructed there to study the action of sunlight on exhausts as basis for determining health effects of irradiated gases. The center also is starting experiments on animals, plants and bacteria for the effects of auto exhausts.

Secretary Flemming has suggested that congress authorize his department to hold hearings and make findings and recommendations in dealing with interstate air pollution problems. He also plans to call together a group representing industry, state and local governments, universi-

ties and other research groups. Their job would be to (1) Indicate what should be a "fair share" for federal, state and local communities and for industry and private groups in paying for air pollution control, and (2) Working out practical methods of carrying out conference proposals in medical and engineering research.

Q.Q. Burney Suggests More Emphasis on Facilities, Personnel for Aged.

Health care of the aged was thoroughly aired during the course of Secretary Flemming's first conference with heads of medical and health organizations on "emerging health needs." PHS Surgeon General Burney said there were some problems in financing the care of the aged, but there may be need for more emphasis on facilities, personnel and administration. He cited the fact that the government had spent over \$1 billion on Hill-Burton facilities yet had spent but a little over \$1 million for research on facilities for various categories of patients.

Spokesmen for the AMA headed by President Gunnar Gundersen, for the American Hospital Association, Blue Shield medical care plans and the Association of Methodist Homes and Hospitals told of various efforts to solve financing of older persons' health care. Dr. Ernest B. Howard, assistant executive vice president of AMA, said it would be "disastrous to jump into a full program so radical" as the free hospital and surgical service bills. Ray Amberg, president of AHA, commented that "we hope to solve this problem without federal aid."

R.R. House Group Attacks HEW on Employment Rise.

The department of health, education, and welfare yesterday came under the attack of a house post office and civil service subcommittee for not cutting back on manpower as proposed by the budget bureau. The latter favors a 2 per cent cut below the level of employment originally projected to be necessary. Subcommittee chairman is Representative Davis (D., Ga.). Assistant HEW Secretary Elliot Richardson explained that HEW employment rose because of increasing services voted by congress and also because of a growing country. He forecast the department would have to ask for supplemental appropriations to pay for some of the new programs. Some committee members accused HEW of "lobbying" a number of the proposals that passed the last session.



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ARE WE TAKING BLUE SHIELD FOR GRANTED?

DOCTORS are just as human as are non-medical people. All people might as well confess that they share all the perversities of human nature — most of which seem so magnified when people become patients.

One of mankind's most dangerous perversities is to take for granted so many of life's blessings which were secured to us only by heroic effort and sacrifice on the part of our forebears.

Thus it is with our political freedom. As John Philpot Curran warned our infant nation in 1790: "The condition upon which God hath given liberty to man is eternal vigilance; which condition if he break, servitude is at once the consequence of his crime and the punishment of his guilt."

Twenty years ago, when the American Medical Association, in special session, endorsed the principle of voluntary health insurance, American doctors in many scattered places began the long, hard task of creating American medicine's own unique instrument that is now known as Blue Shield. Truly, these patriarchs of medicine struck a great blow for freedom when they built this voluntary prepayment program which now serves one of every four Americans.

In support of their efforts, every doctor must apply his energies to further strengthen and refine Blue Shield. Leadership in the affairs of Blue Shield now, and in the future, is a responsibility the doctor cannot delegate nor can permit it to be abridged.

This will secure the real and practical benefits of the Blue Shield program for the public good — a principle to which medicine has always been fundamentally dedicated.

Indeed, American medicine has too great a stake in the future of voluntary health insurance to ignore Blue Shield. For when the doctors created Blue Shield, they not only pioneered the wilderness of prepayment and built one of the main bulwarks against socialized medicine, they also identified themselves with an idea and a program to which the people of America have given a tremendous endorsement.

Eternal vigilance is indeed the price of our freedom in medicine.

AMERICAN CANCER SOCIETY CLINICAL FELLOWSHIP PROGRAM

THE American Cancer Society offers clinical fellowships to institutions for the clinical training of physicians in the field of cancer. These fellowships are not intended to replace the existing residency and fellowship programs in the institutions; rather, they are intended to provide additional positions and opportunities for training physicians. Last year, 140 clinical fellowships were awarded to 63 institutions.

Specialties in which Fellowships are Awarded:

Internal medicine, malignant diseases, neurological surgery, obstetrics and gynecology, orthopedic surgery, otolaryngology, pathology, pediatrics, public health, radiology, surgery, and urology.

Institutions applying for fellowships must be approved by the council on medical education and hospitals of the AMA for residency training in the specialty for which they are applying. *Applications from institutions which do not have this approval cannot be considered.*

Institutional applications:

Institutions wishing to apply for one or more clinical fellowships may do so by submitting their requests on application forms to the Director of Professional Education of the American Cancer Society. In preparing the application, the institution should use only the forms for the year July 1, 1960 to June 30, 1961 and should provide all information requested on the form.

It is especially important to include, in narrative style, a detailed description of the contemplated program and the opportunities available for training in cancer.

Applications must be received in the office of the Society not later than Feb. 15, 1959.

Institutions that have applied will be notified of the disposition of their applications in July 1959.

Individual applications:

Individuals should apply directly to the institution where American Cancer Society clinical fellowships are available for the year July 1, 1960 to June 30, 1961. A list of these institutions may be obtained from the society.

Applications from individuals will be accepted only when nominated by an institution which has been awarded a fellowship. Application forms will be made available to these institutions. *Nominations for these fellowships will be*

done on these forms only.

Qualifications of fellows:

In the nomination of fellows, institutions will give preference to candidates who intend to undergo examination by a specialty board and have the apparent capability of being certified. Fellows must also meet the following requirements:

1. Must be at least in the last two years of residency training, beyond the internship, in the specialty in which they intend to become certified.

2. Must be a citizen of the United States, school in the United States, its territories, or Canada.

3. Must be a graduate of a Class A medical

4. Must not have passed his 41st birthday at the scheduled start of his fellowship.

Noncitizens and foreign medical school graduates will be considered only if the candidate is of exceptional caliber and the institution *requests in writing that these requirements be waived*. Waivers are not encouraged and only a very few exceptional ones are considered.

None of the other requirements will be waived.

Term of fellowship:

Fellowships are granted for one year only, July 1, 1960 to June 30, 1961. A new institutional application must be submitted each year even if the institution wishes to nominate the same individual.

American Cancer Society clinical fellowships will not be awarded for less than a one-year period nor will any individual be awarded more than two one-year fellowships. The holders of these fellowships are not excluded, however from consideration for advanced fellowships.

Required reports on fellowships:

The fellow shall submit an independent report directly to the American Cancer Society describing completely the training received during the one-year fellowship. The director of the service shall also submit an independent report on the work of the fellow. These reports shall be forwarded to the director of professional education within one month of the termination of the fellowship.

In addition, the fellow shall present evidence of active participation in a cancer project, either in the form of a paper suitable for publication, or in a report on personal contribution or participation in work still in progress. This report

shall be forwarded to the director of professional education within three months of the termination of the fellowship.

Stipend:

The stipend for American Cancer Society clinical fellowships is \$3,600 per annum payable in 12 monthly amounts of \$300 directly to the fellow from the office of the American Cancer Society.

Tax exemption:

The Internal Revenue Code (Section 117) states that, in the case of individuals who are not candidates for a degree at an educational institution, the amount of a fellowship grant excluded from gross income in any taxable year shall be limited to an amount equal to \$300 times the number of months for which the recipient received stipend limited to a total of 36 months which need not necessarily run consecutively. It is further provided that gross income does not include amounts received to cover expenses for travel, research, clerical help or equipment which are incident to the fellowship to the extent of such amounts as are expended by the recipient.

Schedule for clinical fellowships:

Feb. 15, 1959, deadline date for receipt of applications in office of American Cancer Society.

June 1959, consideration of application by committees of the society.

July 1959, notification to institution of decision by society.

April 1, 1960, deadline date for nomination and receipt of individual application of fellow from institution. Institutions that do not nominate by this date will have their awards forfeited.

July 1, 1960, beginning of fellowship.

BOOK REVIEWS

SO YOU WANT TO BE A DOCTOR
by Allan E. Nourse. 189 pages. (1957 Harper. \$2.75.)

It is the reviewer's opinion that this book should be read by every premedical student and should be on the desk of every premedical adviser. An unusually clear account of what is in store for students who plan on medicine as a career gives useful information and sane advice about the preparatory period, applications to medical schools, and life in the medical school itself.

Stacey's Medical Books, San Francisco, Calif.

GRANT SUPPORT FOR PG TRAINING IN PSYCHIATRY

THE National Institute of Mental Health is offering grant support for a training program for general practitioners and other physicians engaged in the practice of medicine other than psychiatry. Funds are available during the current year (fiscal year 1959) for these grants and training institutions may submit applications at any time.

The program has two purposes:

I. To foster the development of postgraduate training in psychiatry for the practitioners who wish to increase their psychiatric knowledge and skills in order to be able to deal more effectively with the emotional aspects of illness generally and in order to play a more effective role in the treatment and prevention of mental illness. These courses will be designed for the physician who plans to continue practicing in his own field.

Grant support is being offered to medical schools, hospitals, clinics, and medical and psychiatric societies for the development and expansion of such postgraduate training in the form of courses, institutes, and seminars. This support does not include fees, subsistence, or travel for the physicians who attend.

Support of this type of training may be for a particular professional group over a given period, or for training offered regularly as part of the postgraduate curriculum of a medical school, hospital, or clinic, or as part of the educational program of a medical or psychiatric society.

Physicians interested in obtaining this type of training should apply to medical schools, hospitals, clinics, and medical or psychiatric societies which have, or are developing, such training opportunities.

II. To provide support at an adequate level for psychiatric residency training for physicians in practice who wish to become psychiatrists. Training stipends up to a maximum of \$12,000 a year are available. The level of payment will be determined by the training institutions who will also make the award to the individual physicians. The National Institute of Mental Health will make awards of grants for this purpose to training institutions and not to individuals.

Physicians interested in support for this type of training should apply to training institutions which are approved for psychiatric residency training.

Inquiries about the program should be sent to Dr. Seymour D. Vestermarck, Chief, Training Branch, National Institute of Mental Health, National Institutes of Health, Bethesda 14, Md.

BERNARD M. BARUCH ESSAY AWARD

Sponsored by the
**AMERICAN CONGRESS
OF
PHYSICAL MEDICINE
AND REHABILITATION**

AN ANNUAL award of \$100 will be given as a prize for an essay on any subject relating to physical medicine and rehabilitation. The following rules and regulations apply:

1. Any subject of interest or pertaining to the field of physical medicine and rehabilitation may be submitted.

2. Manuscripts *must be* in the office of the American Congress of Physical Medicine and Rehabilitation, 30 N. Michigan Ave., Chicago 2, Ill., not later than March 2, 1959.

3. Contributions will be accepted from medical students only.

4. The American Congress of Physical Medi-

cine and Rehabilitation shall have the exclusive right to publish the winning essay in its official journal, the *Archives of Physical Medicine and Rehabilitation*.

5. Manuscripts must not exceed 3,000 words (exclusive of headings, references, legends for cuts, tables, etc.), and the number of words should be stated on the title page. An original and one carbon copy of the manuscript must be submitted.

6. The essay must not have been published previously.

7. The winner shall receive a cash award of \$100.

8. The winner shall be determined by the essay award committee composed of four members of the American Congress of Physical Medicine and Rehabilitation.

9. All manuscripts will be returned as soon as possible after the name of the winner is announced. The winning manuscript becomes the exclusive property of the American Con-

*even when the causative organism
may be a "persistent staph"*

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AS PROVED BY extensive clinical trials—an over-all success rate of more than 94% was achieved in a total of 3,280 cases.†

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New Pediatric Drops (raspberry-flavored), 10cc. bottle, 5 mg. per drop, plastic calibrated dropper.

Average dosage: For adults, 1-2 Gm. daily in divided doses; proportionately less for children, depending on age, weight, and severity of infection.

†Literature and bibliography available on request.

*Trademark

gress of Physical Medicine and Rehabilitation.

10. The American Congress of Physical Medicine and Rehabilitation reserves the right to make no award if, in the judgment of the essay award committee, no contribution is acceptable. Announcement of the winner will be made at the annual meeting.

The typical American nowadays sees a physician almost twice as often as did his counterpart 30 years ago, according to Health Information Foundation — almost five visits per person a year today compared with only 2.6 in the 1928-31 period.

* * *

Persons in low-income groups now see a physician almost as often as those in high-income groups, says Health Information Foundation. Thirty years ago, by contrast, high-income families averaged about half again as many visits to doctors as did those with the lowest incomes.

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BOARD OF MEDICAL EXAMINERS STATE OF ARIZONA

826 Security Building
Phoenix, Ariz.

THE Board of medical examiners of the State of Arizona at a regular meeting held Saturday, Oct. 18, 1958, issued certificates to practice medicine and surgery in this state to the following doctors of medicine:

Benson, Kenneth Haworth (OALR), Sedona, Ariz.

Browning, Joseph Allan (Pd), 1816 Eastlawn, Durango, Colo.

Bullington, James Daniel (Ca), 550 West Thomas Road, Phoenix, Ariz.

Burse, William James (GP), 1604-A East Camelback Road, Phoenix, Ariz.

Hare, Jr., Donald Eugene (GP), Maricopa Co. General Hosp, Phoenix, Ariz.

Keppleman, George Kieve (GP), 107 Tapscott Street, Brooklyn 12, N. Y.

Monahan, James Raymond (R), 328 Broadway, Reno, Nev.

Nelson, Arthur Ryden (GS), 1046 Riverside Ave., Jacksonville, Fla.

Richerson, Hal Bates (GP), Holbrook Clinic, Holbrook, Ariz.

Robertson, George Duncan (GS), Pima Co. General Hospital, Tucson, Ariz.

Sandor, Imre Miklos (I), 200 East Monterey Way, Phoenix, Ariz.

Skankey, Robert Alan (GP), 519 West Palm Lane, Scottsdale, Ariz. (home)

Spriggs, John Thomas (I), Pima Co. General Hospital, Tucson, Ariz.

Wang, Stanley (GP), 1513 West Thomas Road, Phoenix, Ariz.

Williams, Gene Varner (OALR), Univ. of Kansas Medical Center, Kansas City.

Worrell, Janet (I), 550 West Thomas Road, Phoenix, Ariz.

Health Information Foundation calls recent improvements in safety to women in childbearing "an almost unparalleled achievement of medical progress." Maternal factors now cause only one-tenth of 1 per cent of all deaths in this country and only 4 per cent of all deaths among women of reproductive age.

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nutritionally**

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lactation
convalescence
deficiency states
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Pyridoxine	
Hydrochloride (B ₆)	5 mg.
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(vitamin C)	250 mg.

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LOCATION OPPORTUNITIES

ASHFORK — Pop. 700 — North centrally located — Railroad center — Contact the Women's Club, Ashfork, Ariz.

CAMP VERDE — Located in the heart of a large farming and ranching area on the Verde River. Approximately 100 miles north of Phoenix. Badly in need of a medical doctor. Contact Ivy N. Moser, R.N., Camp Verde, Ariz.

GILA BEND — Pop. 2,500 — 80 miles west of Phoenix — Nearest town to the Painted Rock Dam Project — Good opportunity for general practitioner. Cattle, cotton, and general farming. Office and equipment available. \$150 monthly income from board of supervisors. Contact Mrs. J. F. Allison, Box 485, Gila Bend, Ariz.

HAYDEN — Pop. 3,000/4,000. Industrial practice — approximately 200 employees and dependents. Only part-time required. Coverage; Metropolitan Surgical Plan. Physician may engage in private practice also. Small company-owned clinical building (new) available for use, with X-ray equipment, diathermy equipment, etc. Full-time nurse available to assist; clerical work to be handled by company. Company housing facilities available for physician — small rental. Contact: American Smelting & Refining Company, Mr. Ben Roberts, department manager, P. O. Box 1111, El Paso, Texas.

HOLBROOK — Population above 7,000. Located in the heart of the northeastern pine country of Arizona on U. S. Route 66. Need services of GP. For full details, contact Donald F. DeMarse, M.D., 397, Holbrook, Ariz.

MIAMI — Opportunity for GP — Industrial hospital staffed by approximately seven doctors, who care for personnel and families of those who work for the three principal mining companies. Community served by many mining and ranching interests. Contact Robert V. Horan, M.D., Miami-Inspiration Hospital, Miami, Ariz.

MORENCI — Mining community near New Mexico-Arizona border. Pop. 10,000. Has vacancy at hospital for GP. Contact Carl H. Gans, M.D., Morenci Hospital, Morenci, Ariz.

PAGE — Population growing by leaps and bounds at the site of the new Glen Canyon Dam project. Current estimates are 6,000 to 8,000 total. Only one M.D. is now located in Page and he has facility available. Located about 90 miles north of Flagstaff, Ariz., the building project is estimated to be concluded in 10 years. Write Ivan W. Kazan, M.D., 16 H, Page, Ariz., for full

details.

SAFFORD — Graham County Health Department in need of an M.D. In the heart of the cattle and farming areas of southeastern Arizona. Population of 10,500 and elevation is 2,920. Schools, churches and social facilities are numerous. Contact Mr. Verl Lines, Chairman, Graham County Board of Supervisors, Safford, or Frederick W. Knight, M.D., 618 Central Ave., Safford.

ST. JOHNS — Seriously need a doctor of medicine, preferably a general practitioner, in this east-central Arizona community. Population is approximately 1,500 with several other small towns in the general area. About 20 miles from New Mexico in the beautiful rim country of Arizona. Contact Donald F. DeMarse, M.D., Box 397, Holbrook, Ariz.

TOLLESON — In need of GP. Serves a trading population of from 12,000 to 15,000. Ten miles west of Phoenix, with elementary and high schools, churches of all denominations. Complete office and equipment for GP is available on reasonable term lease or purchase. Contact Mr. Peter Falbo, President, chamber of commerce, 9112 West Van Buren St., Tolleson, Ariz.

TUCSON — The VA Hospital is in urgent need of an orthopedic surgeon. They prefer someone who is board certified, but would take someone who has had special training as they have the local men in this field available for consultation service. State license is necessary (but not necessarily an Arizona license). Contact S. Netzer, M.D., Director, Professional Service, VA Hospital, Tucson, Ariz.

TUCSON — Young man interested in the practice of internal medicine for junior associateship, Southwestern Clinic & Research Institute, Inc. Excellent opportunity to achieve qualification in the specialty of internal medicine. Contact Charles A. L. Stephens Jr., M.D., 2430 East Sixth St., Tucson Ariz.

FOR INFORMATION ON OPPORTUNITIES IN THE FIELD OF INDUSTRIAL MEDICINE, CONTACT:

Harold J. Mills, M.D., Phelps Dodge Hospital, Ajo, Ariz.

Carl H. Gans, M.D., Phelps Dodge Hospital, Morenci, Ariz.

Ira E. Harris, M.D., Miami-Inspiration Hospital, Miami, Ariz.

Charles B. Huestis, M.D., Box 928, Hayden, Ariz.

Elvie B. Jolley, M.D., Copper Queen Hospital, Bisbee, Ariz.

H. W. Finke, M.D., Magma Copper Company

Hospital, Superior, Ariz.

John Edmonds, M.D., Kennecott Copper Corporation Hospital, Ray, Ariz.

Francis M. Findlay, M.D., San Manuel Hospital, San Manuel, Ariz.

LOCATION INQUIRIES

DAPOLITO, JOHN J., JR., M.D., 356 Union St., Hudson, N.Y.; *I*; 1953 graduate of Albany Medical College; interned at Albany Hospital, Albany, N. Y.; served residency at Albany Hospital; holds licenses in New York and California; age 31; married; interested in group or associate practice. Available immediately.

DERIAN, PAUL S., M.D., 196 South Greenwood St., Marion, Ohio; *Or*; 1951 graduate of University of Virginia; interned at St. Vincents Hospital in New York City; served residency at University of Virginia; holds licenses in Virginia, West Virginia and Ohio; age 36; married. Interested in industrial or private practice. Available May 1959.

GARDNER, AUSTIN LEONARD, M.D., 57 E. 38th St., Apt. 205, Indianapolis, Ind.; *S*; 1952 graduate of Indiana University School of Medicine; interned at Bellevue Hospital in New York; served residency at Bellevue Hospital; holds licenses in Indiana and New York; fulfilled his military obligations; age 32; married. Interested in group or associate practice. Available immediately.

LAMB, ROBERT JAMES, M.D., 706 Begole St., Flint, Mich.; *GP*; 1957 graduate of Albany Medical College; interned at Hurley Hospital in Flint, Mich.; military status, Class 2-A; holds license in the state of Michigan; age 27; married; interested in group or associate practice. Available now.

LONG, WILLIAM ALEXANDER, JR., M.D., Box 66, Hazlehurst, Miss.; *GP*; 1955 graduate of Tulane University School of Medicine; interned at Colorado General Hospital in Denver; completed two years active duty, now in inactive reserve; holds license in Mississippi and national board certificate; age 28; single; interested in group or associate practice; available July 1, 1961.

MCDONALD, RICHARD T., M.D., 7610 Kipling, Detroit, Mich.; *GS*; 1954 graduate of University of Nebraska; interned at San Bernardino County Hospital; served residency at Henry Ford Hospital in Detroit; holds licenses in Nebraska and Michigan; fulfilled his military obli-

gations; age 31; married; interested in assistant or associate practice. Available immediately.

MOORE, ROWE PRICE, M.D., 1610 N.W. 19th St., Miami 35, Fla.; *U*; 1953 graduate of Temple University; interned at Southern Pacific General Hospital in San Francisco; served residency at VA Hospital in Albuquerque, N. M.; fulfilled military obligations; holds license in state of Florida and national boards certificate; age 33; married. Interested in clinic, assistant or associate practice. Available July 1, 1959.

NENAD, ROBERT E., M.D., 231 Paramount Drive, Millbrae, Calif.; *I, Pd.*; 1957 graduate of Western Reserve University School of Medicine; interned at St. Luke's Hospital in Cleveland, Ohio; served residency at VA Hospital in San Francisco; holds licenses in Ohio and California; fulfilled military obligations; age 31; married. Interested in general, clinic, industrial, assistant or associate practice. Available — approximately November 1959.

RECHLITZ, ERVIN T., M.D., 419 Pleasant St., Beloit, Wis.; *Oph*; 1937 graduate of Marquette University; interned at Milwaukee County Hospital; served residency at Misericordia Hospital in Milwaukee; holds licenses in Wisconsin, Minnesota and Colorado; fulfilled his military obligations; age 46; married; will accept group practice but prefers associate practice. Available immediately.

SHOAF, ROY RAYMOND, M.D., 4617 "A" N. Winchester, Chicago, Ill.; *Ob-Gyn*; 1952 graduate of University of Kansas; interned at William Beaumont Army Hospital in El Paso, Texas; served residency at University of Illinois in Chicago; holds license in the state of Kansas; fulfilled military obligations; age 36; married. Interested in group or associate practice. Available July 1959.

The maternal mortality rate in this country has declined 93 per cent in the last four decades, Health Information Foundation points out. One maternal death occurs in approximately 2,300 live births today, compared with one maternal death for each 165 live births in 1915.

Future Meetings

THE ARIZONA MEDICAL ASSOCIATION, INC.

68TH ANNUAL MEETING PROGRAM

IN accordance with direction of the scientific assembly committee at its last meeting, Doctor Melick reviewed progress to date in the development of the program schedule for the 68th annual meeting of the association to be held in Chandler, Ariz., April 28 through May 2, 1959, at the San Marcos Hotel. Below is listed those invited guests who have accepted the invitation:

Bowers, John L. (M.D.) — Dean, University of Wisconsin Medical School.

Carrier, Haddon M. (M.D.) — Mayo Clinic, Rochester, Minn.

Cline, John W. (M.D.) — Associate Professor of Surgery, Stanford University School of Medicine.

Fagg, Jr., Fred Dow (Ph.D.) — President, WICHE.

Gustavson, Reuben G. (Mr.) — President, Resources for the Future.

Hard, Walter L. (M.D.) — Dean, University of South Dakota, School of Medicine.

Jenkins, Harold Dalton (M.D.) — Assistant Professor of Medicine, University of Colorado Medical Center.

Johnson, Marvin E. (M.D.) — Assistant Professor of Surgery, University of Colorado Medical School.

Kessler, Henry H. (M.D.) — Director, Kessler Institute for Rehabilitation.

Lippard, Vernon W. (M.D.) — Dean, Yale University School of Medicine.

Pullen, Roscoe L. (M.D.) — Dean, University of Missouri School of Medicine.

Royce, Thomas L. (M.D.) — Clinical Assistant Professor in Ophthalmology, Baylor University School of Medicine.

Turner, Thomas B. (M.D.) — Dean, Medical Faculty, Johns Hopkins University School of Medicine.

Tuesday, April 28, 1959

1 p.m. — Council meeting.

Wednesday, April 29, 1959

9 a.m. — House of delegates — special session.

2 p.m. — Blue Shield corporate meeting followed by board of directors meeting.

6:30 p.m. — Reception.

7:30 p.m. — Buffet supper.

Thursday, April 30, 1959

8 a.m. — House of delegates — first regular session.

9:30 a.m. — General session (in usual order).

10 a.m. — Scientific session.

10 a.m.-10:30 a.m. — Henry H. Kessler, M.D.

10:20 a.m.-10:40 a.m. Harold Dalton Jenkins, M.D.

10:40 a.m.-11 a.m. — Thomas L. Royce, M.D.

11 a.m.-11:20 a.m. — Break.

11:20 a.m.-11:40 a.m. — Haddon M. Carrier, M.D.

11:30 a.m.-12 noon — Marvin E. Johnson, M.D.

12 noon-12:20 p.m. — John W. Cline, M.D.

12:20 p.m. — Luncheon (not sponsored).

2:30 p.m. — Surgical Symposium (To be announced).

Friday, May 1, 1959

It was determined that the Friday (May 1, 1959) schedule be as follows:

7:30 a.m. — Breakfast with Doctor John W. Cline as guest speaker.

9 a.m. — Regular sessions on medical education with Doctor John W. Cline as moderator.

9 a.m. — Speaker — Vernon W. Lippard, M.D.

9:20 a.m. — Speaker — Walter L. Hard, Ph.D.

9:40 a.m. — Speaker — Thomas L. Royce, M.D.

10 a.m. — Speaker — John Z. Bowers, M.D.

10:20 a.m. — Speaker — Roscoe L. Pullen, M.D.

12:30 p.m. — Luncheon — Speaker — Mr. Reuben G. Gustavson.

NOTE: No specialty group luncheon meetings to be provided on this day.

2:30 p.m. Panel discussion with Marvin E. Johnson, M.D., Fred Dow Fagg Jr., Ph.D., and Thomas B. Turner, M.D., followed by a medical school workshop symposium.

NOTE: It was suggested that possibly Doctors Johnson and Royce might dwell on the subject: "Relationship of the Private Practitioners to a Medical School."

5 p.m. — Summarization by John W. Cline, M.D.

5:15 p.m. — Press conference.

6:30 p.m. — Reception.

7:45 p.m. — President's dinner dance.

Saturday, May 2, 1959

8 a.m. — House of delegates — second regular session.

10 a.m. — Scientific session (To be announced)

EXHIBITS**Technical:**

Provision is being made providing for 48 technical exhibits to be accommodated in the entrance arcades of the San Marcos Hotel, Arizona Attractions, Inc., of Phoenix to be employed for erection of back and side-wing frames, etc. Ap-

proved.

Scientific:

It was agreed to provide space for scientific exhibits to the extent of available space. Applications therefor currently in hand include the safety committee and poisoning control committee of the association.

**7TH ANNUAL CANCER SEMINAR
Of the Arizona Division
AMERICAN CANCER SOCIETY**

January 22-24, 1959 — Paradise Inn — Phoenix, Arizona

THURSDAY, JANUARY 22**9:00 A.M. — OPENING SESSION**

Invocation

Introductory Remarks

Edward H. Bregman, M.D.

Chairman, Seminar Committee

9:15-10:00 A.M. — ANEMIA OF MALIGNANT DISEASE

Speaker — Alfred Gellhorn, M.D.

Moderator — Alloys Tallakson, M.D.

10:00-11:15 A.M. — HODGKINS DISEASE, RELATION OF VIRUSES TO HODGKINS DISEASE

Speaker — Warren Bostick, M.D.

Moderator — W. A. Brewer, M.D.

11:15-12:30 P.M. — RECENT ADVANCES IN DIAGNOSIS AND TREATMENT OF CARCINOMA OF THE CERVIX

Speakers — Howard Hunt, M.D., and

Alexander Brunschwig, M.D.

Moderator — Darwin Neubauer, M.D.

12:30 LUNCH**2:30-4:30 P.M. — TUMORS OF CENTRAL NERVOUS SYSTEM**

Speakers

James W. Kernohan, M.D.

Phillip Hodes, M.D.

Edwin B. Boldrey, M.D.

Moderator — John Eisenbeiss, M.D.

FRIDAY, JANUARY 23**9:00-10:00 A.M. — Rol Laughner Memorial Lecture: Treatment of Malignant Disease in the U.S.S.R.**

Speaker

Alexander Brunschwig, M.D.

Moderator — Reed Schupe, M.D.

10:00-10:30 A.M. — A NEW METHOD FOR DIAGNOSIS OF SOLITARY LESIONS OF THE LUNG

Speaker — L. H. Garland, M.D.

Moderator — Robert Leonard, M.D.

10:30-12:00 A.M. — CARCINOMA OF THE LUNG

Speakers

Richard Overholt, M.D.

W. A. D. Anderson, M.D.

Moderator — D. W. Melick, M.D.

12:00 ANNUAL REPORT, AMERICAN CANCER SOCIETY

Kenneth Clark, M.D., Vice President for Medical Affairs, ASC

Moderator — Arthur J. Present, M.D.

2:00-4:30 — CLINICAL AND PATHOLOGICAL DIAGNOSTIC PROBLEMS

All Participants

Moderator — James D. Barger, M.D.

SATURDAY, JANUARY 24**9:00-10:00 A.M. — REVIEW OF CHEMOTHERAPEUTIC AGENTS**

Speaker — Alfred Gellhorn, M.D.

Moderator — Thomas Bate, M.D.

10:00-12:00 A.M. — TUMORS OF THE STOMACH

Speakers

L. H. Garland, M.D.

Alexander Brunschwig, M.D.

W.A.D. Anderson, M.D.

Moderator — Paul Jarrett, M.D.

SAT. AFTERNOON — NURSES SEMINAR

Paradise Inn, Phoenix, Arizona

Saturday, Jan. 24

- 9 a.m. — Opening Session.
 Greeting — Robert B. Leonard, M. D.
 Welcome — Jefferson I. Brown, R.N.
 9:15 a.m. — Nursing and the CA patient —
 Clare Richmond, R.N.
 10:30 a.m. — Nurse and the cytology program
 — Preston Brown, M.D.
 12 noon — Lunch — Medicine and nursing in
 Russia. Alexander Brunschwig, M.D.

2:30 p.m. — Chemotherapeutic agents and the
 nurse. Alfred Gellhorn, M. D.

3:30 p.m. — (Subject to be announced).
 Phillip Hodes, M.D.

Moderator: Robert B. Leonard, M.D.

Co-sponsored by:

Arizona Division, American Cancer Society.
 Arizona League of Nurses.
 Arizona State Nurses Association.
 Arizona State Department of Health.

SECOND ANNUAL CARDIAC SYMPOSIUM

ARIZONA HEART ASSOCIATION

Jan. 30, 31, 1959

Arizona Biltmore Hotel, Phoenix

Symposium Committee

Dr. Robert Bullington
 Dr. Leslie Kober
 Dr. Earl Baker
 Dr. David Long
 Dr. Shaw McDaniel
 Dr. Tom Reed

Friday, Jan. 30

- 9:00 a.m. — Greetings by Dr. Elmer E. Yeoman, Tucson
 9:15-10:15 — "Studies in Spatial Vectorcardiography," Dr. George E. Burch, New Orleans
 10:15-10:30 — Intermission
 10:30-11:30 — The Problem of Arteriosclerosis, Dr. Irvine H. Page, Cleveland
 11:30-12:30 — Changing Concepts in the Surgery of Atherosclerotic Occlusive Diseases, Dr. Michael E. DeBakey, Houston
 12:30-2:00 — Lunch
 2:00-3:00 — Interesting Aspects of the Aging Process, Dr. George E. Burch, New Orleans
 3:00-4:00 — Diagnostic Applications of Indicator Dilution Curves with Particular Refer-

ence to Right and Left Heart Sampling, Dr. H. J. C. Swan, Rochester, Minn.

4:00-5:15 — Intermission

4:15-5:00 — Panel Discussion, Dr. Robert H. Bullington, Moderator

7:00-8:00 — Cocktail Party

8:00 — Dinner and Dancing at Arizona Biltmore Hotel

Saturday, Jan. 31

9:00 — Greetings by Dr. Donald K. Buffmire, Phoenix

9:15-10:15 — Subject to be announced later, Dr. S. Gilbert Blount, Denver

10:15-10:30 — Intermission

10:30-11:30 — On the Pulmonary Hypertension Associated with Defects in the Interatrial and Interventricular System, Dr. H. J. C. Swan, Rochester, Minn.

11:30-12:30 — Surgical Consideration of Aneurysms of the Aorta, Dr. Michael E. DeBakey, Houston

12:30-2:00 — Luncheon

2:00-3:00 — The Nature and Treatment of Hypertension, Dr. Irvine H. Page, Cleveland

3:00-4:00 — Subject to be announced later, Dr. S. Gilbert Blount, Denver

4:00-4:15 — Intermission

4:15 — Panel Discussion, Dr. Elmer E. Yeoman, Tucson, Moderator.

THE DALLAS SOUTHERN CLINICAL SOCIETY 28TH ANNUAL SPRING CLINICAL CONFERENCE

March 23, 24, 25, 1959

Featuring:

General assemblies, round table luncheons, (medical, surgical, EENT, orthopedic, urological, pediatric, Ob.-Gyn.), post-graduate lectures,

panel discussions, clinical pathological conference, technical exhibits, and dinner dance.

UNIVERSITY OF UTAH PG ANESTHESIA

THE University of Utah College of Medicine will conduct its Fourth Postgraduate Course in Anesthesiology from Feb. 9 through 12th, 1959.



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and relieve the
symptom complex

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Tetracycline-Antihistamine-Analgesic Compound Lederle

Sinusitis, otitis, tonsillitis, adenitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.⁽¹⁾ To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN[®] Tetracycline HCl (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP, caffeine-free.

(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H., *Am. J. Hygiene* 71:122, Jan. 1933.



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SURGICAL MEETING IN HOUSTON, TEXAS, FEB. 2-4, 1959

ALL MEMBERS of the medical profession are invited to attend a three-day sectional meeting of the American College of Surgeons in Houston, Texas, Feb. 2, 3, 4, 1959, at the Shamrock Hilton Hotel.

Reports in general surgery, a full day's otolaryngology program, a cancer workshop, films, and hospital clinics will comprise the three-day meeting.

The special otolaryngology session on Monday, Feb. 2, will include scientific reports and discussions on problems of current concern. The cancer workshop on Wednesday, Feb. 4, is for medical directors of approved cancer programs in Southwestern United States, and its purpose is to improve the professional and administrative aspects of local cancer programs. It is the first program of its type to be conducted in many years, and its success will determine future use of workshops during sectional meetings. Dr. R. Lee Clark Jr., chairman, executive committee of the ACS committee on cancer, is in charge.

General sessions will include discussions on tumors, varicose veins, preparation of parents for parenthood, cancer, radiation hazards, diseases of the pancreas, gastrointestinal tract bleeding, among other topics.

Dr. I. S. Ravdin, chairman, board of regents, will act as moderator at the fellowship luncheon discussion on college activities on Tuesday, Feb. 3. Fellow panelists will include Dr. George W. Waldron, Houston, clinical professor of surgery, Baylor University, and Dr. Albert W. Hartman, San Antonio, clinical professor of surgery, Texas University Postgraduate School, both governors of the college, and, from the college staff, Dr. H. P. Saunders, associate director, and assistant directors, Dr. James B. Mason and Dr. George W. Stephenson.

A preliminary program follows:

Dr. J. Griffin Heard, Houston, will preside over the following opening Monday morning session in general surgery:

Tumors of the Thyroid Gland; Clinico-Pathologic Basis for Treatment. Anthony V. Partipilo, Chicago.

Tumors of the Neck. H. Mason Morfit, Denver.

Varicose Veins. Howard Mahorner, New Orleans.

Newer Techniques in the Management of

Acute Renal Failure. Edward H. Vogel Jr., Lt. Col., MC, Fort Sam Houston.

Preparing Parents for Parenthood. Mario A. Castallo, Philadelphia.

On Monday afternoon, there will be clinics and demonstrations presented by the Baylor University Medical Faculty. Dr. Michael E. De Bakey will preside:

Surgery of the Aortic and Major Arteries. Michael E. DeBakey.

Indications for Open Heart Surgery. Analysis of 500 Cases. Denton A. Cooley.

Diagnostic Angiography. E. Stanley Crawford. Arterial Bypass Below the Knee, or Unusual Coarctations of the Aorta. An Analysis of 20 Cases. George C. Morris Jr.

Use of Blood and Blood Products in Surgery. James D. McMurrey.

Tissue Transplantation. George L. Jordan Jr. Experiences with Surgical Intensive Care Unit. Lee Lyman, Dewey Tuttle, and Presley Howard Chalmers.

Current Surgical Approaches to Coronary Artery Disease. Walter S. Henly.

Improved Evaluation of Residua of Pulmonary Tuberculosis with Combined Pulmonary Arteriography and Bronchography. Riley Foster.

Thoracic Esophageal Diverticula. John W. Overstreet.

New Approach to Adrenal Hypercorticism. Robert C. Overton.

Use of Marlex Mesh in Hernia Repair. Francis Cowgill Usher.

Traumatic Injuries of the Chest. John L. Och-sner.

A motion picture program will be presented Monday evening, with Dr. William D. Seybold, Houston, presiding.

The Houston Ophthalmological and Otolaryngological Society has collaborated in preparing the following all-day otolaryngology program for Monday, Feb. 2, Dr. J. Charles Dickson, presiding:

Facility in Tonsil and Adenoid Management; Conclusions from 2,400 Consecutive Cases. Ben T. Withers, Houston.

Tympanoplasty. James W. McLaurin, Baton Rouge.

Improvement in the Surgery for Protruding Ears. William K. Wright, Houston.

Stapes Mobilization: Technique, Related Path-

ology and Results. Fred Guilford, Houston.

An otolaryngologists' luncheon will follow, after which the afternoon session will be held, with Dr. Charles S. Alexander, Houston, presiding:

(Discussion to follow each paper)

Indications of Inner Ear Versus Retrocochlear Involvement. Jack Bangs, Houston.

Skin Grafts in Tympanoplasty. James W. McLaurin, Baton Rouge.

The Eustachian Tube; Management. Claude C. Cody, Houston.

Tuesday morning's general surgery session will open with a cine clinic film, followed by these reports:

Planned Cholecystostomy. Robert S. Sparkman, Dallas.

Treatment of Tumors of the Parotid Gland. Truman G. Blocker Jr., Galveston.

Esophageal Obstruction. Thomas H. Burford, St. Louis.

Chemotherapy as an Adjuvant to Surgery in Cancer. John Paul North, McKinney, Texas.

Reducing the Mortality of Perforating Wounds of Colon and Rectum. Ben J. Wilson, Dallas.

On Tuesday afternoon, clinics and demonstrations will be presented by the M. D. Anderson Hospital and Tumor Institute of the University of Texas, with Dr. R. Lee Clark Jr., Houston, presiding:

Present Concepts in Cancer Surgery:

Use of the Ileal Pouch for Ureteral Transplantation. Richard G. Martin.

Adjuvant Regional Chemotherapy in Treatment of Malignant Tumors. John S. Stehlin.

Thyroid Cancer. R. Lee Clark Jr.

Radical Surgery for Cancer of the Oral Cavity. William S. MacComb.

Cancer of the Breast:

Selection of Patients for Treatment. E. C.

White.

Radiation Therapy. Gilbert H. Fletcher.

Disseminated Breast Cancer—Hormone Therapy. Nylene Eckles.

Pituitary Ablation. George Ehni.

Dr. Royal W. Rudolph, Tucson, will preside over the Wednesday a.m. program:

Direct Vision Coronary Endarterectomy for Angina Pectoris. William F. Longmire Jr., Los Angeles.

Residual and Resistant Infections. Curtis P. Artz, Jackson.

Colon Anastomoses. Robert M. Moore, Galveston.

Radiation Hazards with Suggestions for Their Control in Diagnostic Procedures. Robert D. Moreton, Fort Worth. (Guest speaker, American College of Radiology.)

Treatment and Significance of Cysts of Iliac Acetabula. G. W. N. Eggers, Galveston.

Dr. George W. Waldron, Houston, will preside over a symposium on diseases of the pancreas, 1-2:30 p.m.:

Management of Chronic Relapsing Pancreatitis. Wiley F. Barker, Los Angeles.

Value of Pancreatoduodenectomy in Management of Patients with Carcinoma of the Pancreas. George L. Jordan Jr., Houston.

Islet Cell Tumors of the Pancreas. Albert O. Singleton Jr., Galveston.

A panel on Management of Gastrointestinal Tract Bleeding will follow:

Moderator: William P. Longmire Jr., Los Angeles.

Collaborators: Robert M. Moore, Galveston, Robert S. Sparkman, Dallas, and Albert W. Hartman, San Antonio.

Dr. H. Prather Saunders, Associate Director, the American College of Surgeons, is in charge of all sectional meetings for the college.

POSTGRADUATE COURSE ON DISEASES OF THE CHEST

THE council on postgraduate medical education of the American College of Chest Physicians will present the Fourth Annual Postgraduate Course on Diseases of the Chest at the Sir Fran-

cis Drake Hotel, San Francisco, Calif., Feb. 16-20, 1959.

Tuition for this five-day course will be \$100, including luncheon meetings.

Further information may be obtained by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Ill.

ANNUAL SEMINAR CARDIOVASCULAR DISEASES

Jacksonville, Fla.
Feb. 19, 20, 21, 1959

THE sixth annual seminar on cardiovascular diseases will be held on Thursday, Friday and Saturday, Feb. 19 to 21, 1959, at the Prudential Auditorium in Jacksonville, Fla. This course is sponsored by the Northeast Florida Heart Association in co-operation with the division of post-graduate education of the College of Medicine of the University of Florida. This seminar has been accepted for credit by the American Academy of General Practice.

The speakers for the course are Dr. Samuel A. Levine, Clinical Professor of Medicine, Harvard University Medical School; Dr. Irving S. Wright, Professor of Medicine, Cornell University School of Medicine; Dr. A. G. Morrow, Assistant Professor of Surgery, Johns Hopkins Uni-

versity School of Medicine; and Chief, Clinic of Surgery, National Heart Institute; Dr. Victor A. McKusick, Associate Professor of Medicine, Johns Hopkins University School of Medicine; Dr. Max Michael Jr., Clinical Professor of Medicine, University of Florida, College of Medicine; and Executive Director, Jacksonville Hospitals Educational Program, Inc.; Dr. William J. Taylor, Assistant Professor of Medicine, University of Florida, College of Medicine; and Dr. Myron W. Wheat Jr., Assistant Professor of Surgery, University of Florida College of Medicine.

This course will include recent developments in the diagnosis and treatment of cardiovascular diseases. The formal lectures will be correlated with panel discussions and question periods in which the entire staff will participate.

Information may be obtained from Dr. Daniel R. Usdin, M.D., Chairman, Cardiovascular Seminar, Northeast Florida Heart Association, 1628 San Marco Boulevard, Suite 7, Jacksonville 7, Fla.

CALENDAR OF MEETINGS

DATE	MEETINGS	PLACE
Jan. 1959		
4-7	Southeastern Region Meeting International Coll. of Surgeons	Miami, Fla.
Feb.		
5-8	American Coll. of Radiology, Annual Meeting	Chicago, Ill.
March		
9-12	AMA 4-day Sectional Meeting	St. Louis, Mo.
16-20	National Health Council Annual Meeting	Chicago, Ill.
30 - Apr. 2	Southwestern Surg. Congress	Denver, Colo.
April		
6-8	American Radium Society	Homestead Hotel, Hot Springs, Va.
6-9	American Academy of General Practice	San Francisco, Calif.
9-12	American Ass'n. for Cancer Research Inc.	Haddon Hall, Atlantic City, N. J.
20-23	American Ass'n. Pathologists & Bacteriologists	Boston, Mass.
20-24	American College of Physicians	Conrad Hilton Hotel, Chicago, Ill.
28 - May 2	Arizona Medical Association	Chandler, Ariz.

The early 20s are the safest years for child-bearing, Health Information Foundation reports. For every 10,000 live babies born to women in the 20-24 year-old group today, only 3.2 maternal deaths occur.

According to Health Information Foundation, at least 94 per cent of all live births in this country nowadays occur in hospitals, and 97 per cent of all births come with a physician in attendance.

Now-All cold symptoms can be controlled



Provides Triaminic for more complete and more effective relief from nasal and paranasal congestion because of systemic transport to *all* respiratory membranes—without drawbacks of topical therapy.[†]

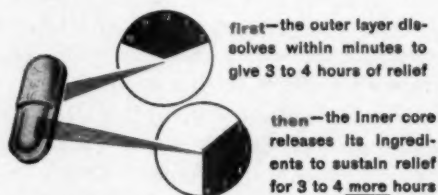
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Provides terpin hydrate, classic expectorant to thin inspissated mucus and help the patient clear the respiratory passages.

[†]Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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Woman's Auxiliary

MENTAL HEALTH

THESE DAYS it is all too easy to collect examples of impressive-sounding, high-flown phrases which mean precisely nothing, as perfected by the advertising profession. We have all grown so accustomed to being harangued by meaningless catch-phrases about this product or that cause that we scarcely listen any more — and that is a pity, because now and then we come upon an often heard and familiar phrase that *does* deserve attention. It is quite common to hear or read about “mental health” — but what is it?

Mental health, insufficiently described as the absence of mental disease, probably should be viewed as varying with time, place, culture and mental capacities of individuals¹. This is the dominant point in the first volume of a 10-volume series to be published by the Joint Commission on Mental Illness and Health, a group of 37 voluntary and government agencies making a three-year study of mental health. The first book, “Current Concepts of Mental Health,” by Marie Jahoda, Ph.D., of London, England, attempts to clear the air for the series by defining the term “mental health.” Both “absence of mental disease” and “normality” are rejected by Dr. Jahoda as unsatisfactory definitions, but she offers six approaches to a more positive one.

Attitudes of the individual toward himself.

Degree to which a person realizes his potentialities through action.

Unification of function in the individual's personality.

Individual's degree of independence of social influences.

How the individual sees the world around him.

Ability to take life as it comes and master it.

A minimum definition, compatible in American culture with most mental health concepts, is that submitted by Dr. Jahoda: “An individual should be able to stand on his own feet without making undue demands or impositions on others.”

Education Is Goal

With this definition, we have a “foot in the

door” leading to the primary goal — education, of ourselves as well as the public. A healthy home, where the principles of good mental health are understood and practiced, is the first level in this education process. The second level is a healthy community — a personal, active interest and co-operation in any community effort to promote good mental health is the first step toward that achievement. These are the prophylactic measures, but what of the mental patients, hospitalized or not, who need help now?

Again, education is the goal. Be informed on the problems of overcrowding and insufficient staff in the state hospital, and no means of acquiring additional well-trained personnel without the funds to pay them. Get to know your “friendly neighborhood psychiatrist” (he doesn't *really* shrink heads, you know) and *talk* to him — ask him about the problems of caring for the mentally ill. Chances are he'll mention the fact that in Arizona there are *no* facilities available for in-patient treatment of psychotic children other than the state hospital.² For obvious reasons this is most undesirable. As for out-patient therapy, there are two child guidance clinics in the state (Phoenix and Tucson) and we need many more.

Then — after you've acquired a few talking points — tackle your local and state legislators. Ask them — get their views on how we go about getting the necessary legislation to achieve more and better facilities for our mentally ill.

“Never underestimate the power of a woman,” it has been said. Multiply that by the number of active members of the Women's Auxiliary to the Arizona Medical Association, and you have quite a power potential. But even a chain-reaction has to start somewhere. Let us make this year the beginning of real self-education in the field of mental health.

Shirley M. Estes,
Chairman, Mental Health,
Women's Medical Auxiliary

BIBLIOGRAPHY

1. The AMA News, Nov. 17, 1958.
2. Annual Mental Health Report, 1957-1958, Women's Aux. to the Arizona Medical Association.